Detailed Written Order
Oxygen Therapy

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 773-688-1566

Order Date: _____

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Duration: ☐ Lifetime (99) Other _____ months

Indicate prescribed usage and equipment.

☐ **Oxygen Concentrator - stationary unit (E1390)**

☐ ****Portable Oxygen Tank System (E0431 & E0443)**
(Patient must be mobile within the home and portable is not covered if the order is for Nocturnal use only).

O2 @ _____LPM via _____ **for** _____

(select method)	(select duration)
Nasal Cannula	_____hours/day
Oxygen Mask	continuous
PAP mask	Nocturnal use only
Trach Collar	

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, OXYGEN SATURATION TESTING, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes, Face to Face, and testing.

The following criteria must be met for the above selected item to be covered,
(this information is based on Medicare Policy)

* Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, AND
2. The beneficiary's oxygen saturation testing was at 88% or less on room air , AND
3. The qualifying blood gas study was obtained within 2 days of discharge from a hospital or nursing facility or within 30 days from an outpatient visit or overnight oximetry, AND
4. The testing was performed by a physician or by a qualified provider, AND
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

If the above criteria is not met, or proper documentation is not received the oxygen order will be denied as not medically necessary.

**Initial delivery of the portable system is a standard regualtor with E-tanks. If a pulse dose device or portable concentrator is requested the Respiratory Therapist will schedule an evaluation after the patient is home.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.