



**Written Order Prior to Delivery (WOPD)
Oxygen Therapy**

**Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673**

Order Date: _____

Patient Name: _____

Home Phone: _____

Date of Birth: _____

Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Duration: Lifetime (99) Other _____ months

Indicate prescribed liter flow, method of administration, and usage:

O2 @ _____ LPM via <i>(indicate liter flow)</i>	_____ for _____ <i>(select method)</i> Nasal Cannula O2 Mask- Indicate type above. PAP mask Trach Collar or Adapter	_____ <i>(select usage)</i> _____hours/day continuous Nocturnal use only
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In order to qualify for portable oxygen, the patient must be mobile within the home. Also, portable oxygen is not covered when prescribed for Nocturnal use only.

Check one of the following selections:

<input type="checkbox"/> Nocturnal Use Only 1 to 10 LPM Oxygen Concentrator - stationary unit (E1390)	<input type="checkbox"/> Concentrator and Portable Tank System 1 to 10 LPM Oxygen Concentrator - stationary unit (E1390) Cart with E-Tanks and Standard Regulator (E0431 & E0443)	<input type="checkbox"/> Concentrator and Oxygen Conserving Device (OCD) 1 to 6 LPM Oxygen Concentrator - stationary unit (E1390) OCD with Oxygen Tanks (E0431 & E0443) <input type="checkbox"/> Evaluation of my patient by a Respiratory Therapist to qualify for the OCD. Titrate the oxygen setting to achieve an SpO2 of ≥ 90% at rest and during activities of daily living via pulse oximetry. Setup on the appropriate OCD. **
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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 within 30 days from an outpatient visit, nursing facility, 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 regulator with E-tanks. If a pulse dose device is requested the Respiratory Therapist will schedule the evaluation.

Physician Name: _____

NPI: _____

Physician Signature: _____

Date : _____

Physician Phone: _____

Fax: _____