Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

2100 Landmeier Rd | Elk Grove Village, IL 60007
PHONE: 800-834-4234 | FAX: 847-931-7138

Written Order Prior to Delivery
Oxygen/Nebulizer/DME

Patient Name	Insurance ID/Group
Address	Insurance Name Insurance Phone
Phone	Order Date
DOB	Height/Weight
Estimated Length of Need (i.e. 99=lifetime)	ICD-10/Diagnosis

Oxygen

☐ Oxygen Concentrator, E1390 PO2 level (*BCBS pt only*): _____	**Prescription**: LPM: _____ Hrs/Day:_____	
☐ Portable Oxygen System • Gaseous, E0431 & Contents, E0443 • Homefill System, K0738 • Portable Oxygen Concentrator, E1392	Via: ☐ Nasal Cannula ☐ Mask ☐ Nocturnal use only ☐ Bleed into PAP device	
☐ Evaluate & titrate to SaO2 _____% for Portable system w/ conserving device or Portable Oxygen Concentrator	☐ Bleed into Ventilator	

Nebulizers

☐ Nebulizer Compressor w/ Reusable administration set, E0570

☐ w/ mask, A7015 – 1/month
☐ w/ administration set, disposable, A7003 – 2/month **OR**
☐ w/ administration set, non-disposable,

A7005 – 1/6 months

Medication used: _____
Frequency: _____

Wheelchair Manual Bases/Seating/Accessories ***Please provide Hip to Hip Measurement:* _____**

☐ Standard, 15”-20”, K0001	☐ Wheelchair seat cushion, less than 22”, any depth, E2601	☐ Anti-Tipping Device, E0971, each
☐ Hemi (low seat), 15”-20”, K0002	☐ Wheelchair seat cushion, 22” or greater, any depth, E2602	☐ Wheel lock extensions, E0961, each
☐ Lightweight, K0003	☐ Skin protection cushion, less than 22”, any depth, E2603	☐ Safety belt, E0978, each
☐ Extra Heavy Duty, **(wt 650+ lbs or severe spasticity),** K0007	☐ Skin protection cushion, 22” or greater, any depth, E2604	☐ Elevating leg rests, K0195, pair
	☐ Other: _____	☐ Other: _____

Hospital Beds/Accessories; Pressure Reducing Support Surfaces

☐ Semi Electric, w/ any type side rails, with mattress, E0260 ☐ Semi Electric, w/ any type side rails, without mattress, E0261	☐ Trapeze Bar, attached to bed with grab bar, E0910 ☐ Trapeze Bar, heavy duty, **(wt 250+ lbs)**, attached to bed, E0911 ☐ Patient Lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s), E0630
☐ Power pressure reducing mattress overlay/pad, alternating w/ pump, includes heavy duty, E0181 ☐ Gel or gel like pressure pad for mattress, E0185 ☐ Power pressure reducing air mattress, E0277 ***Please provide diagnosis above***	☐ Walker, folding (pick up) adjustable, E0135 ☐ Walker, folding, wheeled, adjustable, E0143 ☐ Walker, heavy duty, w/out wheels, E0148 **(weight 300+ lbs)** ☐ Walker, heavy duty, wheeled, E0149 **(weight 300+ lbs)**

Please attach the following:

- Progress notes/face to face evaluation indicating patient need for prescribed equipment
- Test results (Oximetry, ABG, etc.)
- Patient demographics sheet

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature below certifies the medical need for these items for this patient. This form must be SIGNED and DATED by the prescribing Physician prior to dispensing supplies and medical equipment.

Physician Name		Physician NPI	
Physician Address		Physician Phone	
Physician Signature	No stamps please – not valid by law	Date	