

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

<input type="checkbox"/> Oxygen Concentrator, E1390 PO2 level (BCBS pt only): _____ Select one of the following options in boxes below if patient needs portability:
<input type="checkbox"/> Portable System, gaseous, E0431 & Oxygen contents, gaseous, E0443
<input type="checkbox"/> Homefill system, gaseous, K0738
<input type="checkbox"/> Portable Oxygen Concentrator, E1392

Prescription: LPM: _____ Hrs/Day: _____
Via: <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Mask <input type="checkbox"/> Nocturnal use only <input type="checkbox"/> Bleed into PAP device <input type="checkbox"/> Bleed into Ventilator

Nebulizers

<input type="checkbox"/> Nebulizer Compressor w/ Reusable administration set, E0570
<input type="checkbox"/> w/ mask, A7015 – 1/month
<input type="checkbox"/> w/ administration set, disposable, A7003 – 2/month OR
<input type="checkbox"/> w/ administration set, non-disposable, A7005 – 1/6 months
Medication used: _____
Frequency: _____

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

<input type="checkbox"/> Standard, 15"-19", K0001	<input type="checkbox"/> Wheelchair seat cushion, less than 22", any depth, E2601	<input type="checkbox"/> Anti-Tipping Device, E0971, each
<input type="checkbox"/> Lightweight, K0003	<input type="checkbox"/> Wheelchair seat cushion, 22" or greater, any depth, E2602	<input type="checkbox"/> Wheel lock extensions, E0961, each
<input type="checkbox"/> High Strength Lightweight, K0004	<input type="checkbox"/> Skin protection cushion, less than 22", any depth, E2603	<input type="checkbox"/> Safety belt, E0978, each
<input type="checkbox"/> Extra Heavy Duty, (wt 650+ lbs or severe spasticity), K0007	<input type="checkbox"/> Skin protection cushion, 22" or greater, any depth, E2604	<input type="checkbox"/> Elevating leg rests, K0195, pair
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Hospital Beds/Accessories; Pressure Reducing Support Surfaces

<input type="checkbox"/> Semi Electric, w/ any type side rails, with mattress, E0260	<input type="checkbox"/> Trapeze Bar, attached to bed with grab bar, E0910
<input type="checkbox"/> Semi Electric, w/ any type side rails, without mattress, E0261	<input type="checkbox"/> Trapeze Bar, heavy duty, (wt 250+ lbs), attached to bed, E0911
<input type="checkbox"/> Power pressure reducing mattress overlay/pad, alternating w/ pump, includes heavy duty, E0181	<input type="checkbox"/> Patient Lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s), E0630
<input type="checkbox"/> Gel or gel like pressure pad for mattress, E0185	<input type="checkbox"/> Walker, folding (pick up) adjustable, E0135
<input type="checkbox"/> Power pressure reducing air mattress, E0277	<input type="checkbox"/> Walker, folding, wheeled, adjustable, E0143
Please provide diagnosis above	<input type="checkbox"/> Walker, heavy duty, w/out wheels, E0148 (weight 300+ lbs)
	<input type="checkbox"/> 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	Date
No stamps please – not valid by law	