PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

OXYGEN ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______/______/_________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: __________________ Patient cannot accept deliveries on the following days?
Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis **ICD-10 Code:** ______________________ *Non-Specified Codes will not qualify for Primary Diagnosis	**Secondary Diagnosis** **ICD-10 Code:** ______________________

Please answer questions below.

Date of most recent assessment of patient's oxygen carrying capacity (ABG or % SAT): ____/____/______
(Must be within 30 days of this request and must be preformed on room air)
a. Arterial Blood Gas PO2 ______________mm HG Oxygen Saturation Test _____________% saturation

Has it been established that disease is severe and will improve with this therapy? ☐ Yes ☐ No

Have alternative treatment measures to improve cardiopulmonary function been considered/tried and have been documented as ineffective? ☐ Yes ☐ No

Was Patient in a chronic stable state at time ABG or saturation performed? (Not during an actual illness) ☐ Yes ☐ No

What were the test conditions?:
______________ At rest and/or during activities of daily living _______________ During exercise _______________ During sleep

Name of Physician/Provider Preforming test:______________________________

*If patient does not qualify on room air at rest (not 89% or below), then they need to be tested three ways.

____________ On room air at rest _______________ On room air with exertion ________________ With exertion with oxygen

Please answer questions below if in first question PO2 > = 56-59mm HG or Oxygen Saturation >= 89%.

Are there other conditions that would help qualify the patient for oxygen? (Check all that apply.)

☐ Dependent edema due to Congestive Heart Failure ☐ Cor Pulmonale or Pulmonary Hypertension ______________________
☐ Hematocrit greater than 56% ☐ Other ______________________________

Patient is already on oxygen therapy ______________months ________________years

What type of equipment are you requesting for the patient?
☐ **Portable Only**: Is patient mobile within the home?_________ ☐ **Both Stationary and Portable**: For patient requiring O2 while at rest and mobile

What is the highest flow (LPM) ordered for this patient?
☐ LPM ________ (fill in amount) ☐ Less than 1 LPM
***If an LPM of >4 is ordered, enter recent test results taken while on 4 LPM**
Date of Test: ____/____/______ Arterial Blood Gas PO2 _________mm HG Oxygen Saturation Test ________% saturation

What is the route of administration? ☐ Nasal Cannula ☐ Mask ☐ Trach ☐ Other ________________

What is the duration? ☐ Exertion ☐ Continuous ☐ Other __________________

Order Date: _____/______/______ **Length of Need:** __________ **months**

REFERRAL INFORMATION **Ref #:** ____________________

Practice Name: ______________________________ Fax: ______________________________

Office Address: ______________________________ Email: ______________________________

Phone: ______________________________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ______________________________

Physician Name: ______________________ NPI#: ___________________ Phone: (_______)_______-__________ Ext. _______

Physician Signature: ___________________________ Date: ______/______/_________

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: ___________________________ Date: ______/______/_________

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