Phone: 800-824-1400
Fax: 877-824-1411

Medical Service Company

RESPIRATORY Fax Order Form

Please provide copy of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____

Address : _____

City/Zip: _____

Home Phone/Cell#: _____

Height: _____Weight: _____ D.O.B:_____

All services require a method of payment (Credit Card, Bank Information) in addition to Insurance information prior to delivery.

EMPLOYEE USE ONLY ☐ CC secured

Date Prescribed: _____/_____/_____

Insurance: _____

Diagnosis: _____

Gender:_____ Length of need: _____99_____

☐ Asthma (493) ☐ Bronchiectasis (494) ☐ Hypoxemia (799.02)
Chronic Obstructive: ☐ Bronchitis (491.2) ☐ Asthma (493.2) ☐ CHF (428.0) ☐ COPD (496) ☐ Emphysema (492) ☐ OSA (327.23) ☐ CSA (327.21) ☐ CVA (436) ☐ Abnormality of gait (781.2)

OXYGEN (humidifier, tubing and all related supplies)

☐ Oxygen LPM: _____ Via:_____ ☐ Rest ☐ w/Exertion ☐ Sleeping ☐ Continuous

☐ Concentrator ☐ Portable Oxygen Gas Tank

☐ Evaluate for Conserving Device (provide if appropriate) Maintain O_2 Sat: _____ % (during evaluation)

Per MSC protocol: If minimum is not indicated, O2 Saturation will be maintained at a minimum of 90% . In addition, MSC will also conduct comprehensive oximetry prior to d/c of O2

PULSE OXIMETRY SERVICES (where available)

☐ Comprehensive Oximetry

☐ On Room Air ☐ On Oxygen _____ LPM

☐ Overnight Oximetry

☐ On Room Air ☐ On Oxygen _____ LPM

☐ While on PAP Therapy

SUCTION ☐ Machine

☐ oral ☐trach ☐ Yankauer

Catheter size _____

☐ Canister ☐ Tubing

50 psi compressor

☐ device _____ supplies

NEBULIZER & RESPIRATORY MEDICATIONS

☐ Nebulizer , Frequency of Usage _____

☐ Disposable Admin Set ☐ Non-Disposable Admin Set

☐ Disposable Neb Filter ☐ Neb Mask

Medication name, dosage & frequency (if prescription info is not present)

_____

CPAP/BI-LEVEL with heated humidity (tubing, filters & all related supplies) *PLEASE INCLUDE COPY OF SLEEP STUDY*

☐ CPAP _____ cm H_2O ☐ APAP _____ to _____ cm H_2O ☐ Humidifier ☐ Heated Humidifier

☐ Bi-PAP IPAP = _____ EPAP =_____ ☐ BiPAP Auto EPAP min = _____ IPAP max =_____ PS_____

☐ Bleed in O_2 @ _____ LPM

Mask & Supplies ☐ Mask of Patient Choice (please indicate)_____ ☐ Nasal with Cushions ☐ Full

☐ Replacement Cushion for Nasal CPAP ☐ Replacement Pillows CPAP/BiPAP

☐ Headgear used w/CPAP/BiPAP ☐ CPAP/BiPAP Tubing ☐ CPAP Filter, Disposable (A7038) ☐ CPAP Filter, Reusable (A7039)

☐ Water Chamber ☐ Chin Strap ☐ Non-Heated Tubing ☐ Heated Tubing ☐ Other _____

Height and Weight required for these items:

Ambulatory _____

Wheelchairs & Accessories _____

Hospital Beds & Accessories _____

Other _____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND
1) Patient Name 2) Date Prescribed 3)Physician Signature 4) NPI

Physician's Signature: _____ Date: _____/_____/_____

Physician's Printed Name: _____ Ph:_____ Fax : _____

Address: _____ NPI: _____

Customer Service Hours: Monday-Friday 8:30 am to 5 pm Saturday 9 am to 5 pm 24-hour Emergency Service Available
www.medicalserviceco.com