Medical Service Company

Select Branch or Representative

OXYGEN Fax Order Form

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

Patient Name: _____ ***Date Prescribed:*** _____ /_____ /_____

Address: _____ Insurance: _____

City/Zip: _____ Gender: _____ Length of need: _____99_____

Home Phone/Cell#: _____

Date of Birth: _____

Diagnosis (check box): ☐ COPD ☐ Emphysema ☐ CHF ☐ Chronic Bronchitis ☐ Other: _____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

CONTINUOUS HOME OXYGEN + PORTABLE OXYGEN

☐ Home Oxygen Concentrator

Liter Flow: _____ lpm via nasal cannula ☐ Other: _____

- Portable Oxygen
  - ☐ POC Pulse Setting (1-5): _____ ***POC pulse settings do not correlate to LPM settings.***
  - ☐ Portable Oxygen Gas Tank

☐ Evaluate for POC/Conserving Device Maintain O^2 Sat: ____ %

Per MSC protocol: ***If minimum is not indicated, O^2 Saturation will be maintained at a minimum of 90%.***

POCs available pursuant to MSC criteria.

NOCTURNAL OXYGEN

☐ Home Oxygen Concentrator

Liter Flow: _____

Via:

☐ Nasal Cannula

☐ Bleed into PAP

☐ Other: _____

PULSE OXIMETRY SERVICES

☐ Overnight Oximetry On: ☐ Room Air ☐ Oxygen _____ LPM ☐ PAP Device

TESTING

I have reviewed the qualifying oxygen testing that was completed on

_____ /_____ /_____.

Please provide the following records with each oxygen referral:

- ***Standard written order***
- ***Recent qualifying oxygen testing***
- ***Recent office note documenting need***

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

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

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

www.MedicalServiceCo.com

Scan to place an electronic order

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