Select Branch

RESPIRATORY 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#: _____ Diagnosis: _____

Height: _____ Weight: _____ D.O.B: _____

☐ Asthma ☐ Bronchiectasis ☐ Cystic Fibrosis

Chronic Obstructive: ☐ Bronchitis ☐ Asthma ☐ CHF ☐ COPD

☐ Emphysema ☐ OSA ☐ CVA ☐ Cardio Vascular Disease

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

OXYGEN (humidifier, tubing and all related supplies)

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

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

☐ Evaluate for Conserving Device/POC (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)

☐ Overnight Oximetry

On:

☐ Room Air

☐ Oxygen _____ LPM

☐ PAP Device

SUCTION

☐ Machine ☐ Oral ☐ Trach ☐ Yankauer

Catheter Size _____

☐ Canister ☐ Tubing

50 psi compressor

☐ Device _____ Supplies

NEBULIZER

☐ Nebulizer, Frequency of Usage _____

☐ Disposable Admin Set (1 per 6 mos.) ☐ Non-Disposable Admin Set (2 per month)

☐ Neb Filters (2 per month) ☐ Neb Mask (1 per month)

E-prescribe medications separately to The Medical Service Company or fax to (877) 373-3460. NPI #1972554939

CPAP/BILEVEL with heated humidity (tubing, filters & all related supplies)

Please include copy of SLEEP STUDY.

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

☐ BiLevel IPAP = _____ EPAP = _____ ☐ BiLevel Auto EPAP min = _____ IPAP max = _____ PS _____

☐ Bleed in O_2 @ _____ LPM

MASK & SUPPLIES

☐ NASAL MASK KIT

- Nasal Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Cushions (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ PILLOW MASK KIT

- Pillow Mask (1 per 3 mos.) _____
- Heated PAP Tubing (1 per 3 mos.)
- Nasal Pillows (2 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

☐ FULL FACE MASK KIT

- Full Face Mask (1 per 3 mos.)_____
- Heated PAP Tubing (1 per 3 mos.)
- Full Face Cushions (1 per month)
- Headgear used with PAP mask (1 per 6 mos.)
- Water Chamber (1 per 6 mos.)
- Chinstrap (1 per 6 mos.)
- Disposable Filters (2 per month)
- Non-disposable Filters (1 per 6 mos.)

ADDITIONAL ITEMS ORDERED: _____

_____

ADDITIONAL NOTES: _____

_____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing equipment. 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 ***3) Physician Signature & Signature Date***

2) Date Prescribed ***4) NPI*** ***5) Physician Name***

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

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

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

Name of Agent Completing Form: _____

www.MedicalServiceCo.com