Medical Service Company | MSC Sleep — Division of Medical Service Company

**Please Fax Completed Form to 1-877-824-1411**

# 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: _____ Via: ☐ Nasal Cannula ☐ Other: _____

- Portable Oxygen

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

☐ Portable Oxygen Gas Tank / Homefill Unit

☐ 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

## NEBULIZER & RESPIRATORY MEDICATIONS

☐ Nebulizer & All Related Supplies, Frequency of Usage _____

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

Medication Name*: _____

*Medication name is needed for nebulizer qualification & does not act as a medication prescription.

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

## ADDITIONAL NOTES: _____

**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 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: _____

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