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

Please fax completed form to 1-877-824-1411

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