Physician Order/Certificate of Medical Necessity

ONLINE Sleep Store
Your premier home healthcare provider.

Phone: 844-612-2093 | Fax: 844-612-2094
Email: mott@dhscompanies.com

PATIENT INFORMATION **INITIAL DATE OF ORDER**

Name:_____ Phone #: _____

Address:_____

City:_____ State:_____ Zip: _____

☐ Male ☐ Female

DOB: _____

Height: _____

Weight: _____

DIAGNOSIS CODES/DESCRIPTIONS: (Primary Diagnosis Codes for ordered items.)

PROGNOSIS

- ☐ J44.9 COPD
- ☐ J44.9 Obstructive Chronic Bronchitis w/o exac.
- ☐ J43.9 Emphysema
- ☐ J42 Chronic Bronchitis (NOS)
- ☐ J44.1 Obstruct. Chronic Bronchitis w/ (acute) exac.
- ☐ J45.21 Extrinsic Asthma with (acute) exacerbation
- ☐ J 41.0 Chronic Bronchitis (simple)_____
- ☐ Other_____
- ☐ Other _____

Face-to-Face Exam/Diagnostic Testing (Please attach copies of TESTING) **Date of Face-to-Face Exam:** _____

Qualifying Oxygen Testing Date:_____ Facility:_____

R/A resting:_____% R/A exercise:_____% R/A sleep (nocturnal):_____%

Qualifying Sleep Study:

Date:_____ AHI: _____

☐ Oxygen

(99 = Lifetime) LENGTH OF NEED

Equipment	Directions for Use	Route of Delivery	Other Instructions
Stationary Oxygen: ☐ Concentrator ☐ Other: _____ **Portable Oxygen:** ☐ Cylinders ☐ Self Fill System ☐ Other: _____	☐ _____ LPM Continuously **OR:** ☐ LPM During Sleep/Nocturnally **AND/OR:** ☐ Other: _____ (Include liter flow and duration/ frequency of use, e.g., "with exercise", etc.	☐ Nasal Cannula ☐ Other: _____ _____	☐ Nocturnal Pulse Ox ____ Room Air ____ On O2_____LPM ☐ Conserving Device Evaluation x 1 (Includes at rest and with pulse oximetry and heart rate assessments)

☐ Compressor/Nebulizer

(99 = Lifetime) LENGTH OF NEED

- ☐ Compressor/Neb Kit - Qty/mo. _____
- ☐ Other_____Qty/mo. _____
- ☐ Aerosol Mask - Qty/mo. _____
- ☐ Other_____Qty/mo. _____

Medications/Dosage:_____

Frequency of Use:_____

* Medications must be separately ordered from a pharmacy and are not supplied by the Company.

☐ CPAP/RAD Therapy

(99 = Lifetime) LENGTH OF NEED

☐ CPAP at_____Cm H2O ☐ BILEVEL IPAP / EPAP_____Cm H2O Rate: _____

☐ Other:_____

☐ Heated Humidifier ☐ Cool Passover Humidifier

☐ Nasal Mask ☐ Full Face Mask ☐ Nasal Pillows w/ Frame ☐ Headgear ☐ Chin Strap ☐ Tubing ☐ Filters ☐ Other _____

☐ Clinician to Fit Mask/Nasal Application Device, or (specify) _____

I certify that I am the treating physician/prescriber for the above referenced patient and the prescribed equipment is medically necessary.

PRESCRIBER'S SIGNATURE:_____ DATE:_____

PRINTED NAME:_____ NPI:_____ LIC.#:_____

ADDRESS: **Please review, complete and return via fax to_____. Attach prior face-to-face notes, testing and medical records documentation.**

PHONE:_____ FAX: _____

(Rev. 03/24/2016)