CONFIRMATION OF ORDER — Home Oxygen

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: _____ **Date of Birth:** _____

Order Date: _____ **Insurance:** _____

Physician: _____ **NPI:** _____

DIAGNOSIS

ICD 10 Code	Description

EQUIPMENT/SERVICES

	Quantity	Proc. Code	Item Name/Narrative
☐	1	E1390	Home Oxygen Concentrator
☐	1	K0738	Homefill Portable System
☐	1	E1392	Portable Oxygen Concentrator *(Medicaid & MCO plans excluded)*
☐	1	E0431	Oxygen Backup Tank

OXYGEN PRESCRIPTION

O2 at _____ **LPM via:** ☐ **Nasal cannula** ☐ **Mask** ☐ **Bled into PAP device**

☐ **Continuous** ☐ **Exertion** ☐ **Sleep**

Start Date _____ **Length of Need:** _____ *(99=lifetime)*

PULSE OXIMETRY TESTING

If patient is tested with exercise, 3 test results are required and all tests must be conducted during the same testing session.

Date of test: _____

1. SpO2 Resting Air Room: _____ % ☐ **Testing was done during sleep**

   **If resting room air SpO2 is ≤ 88% STOP, no other testing is needed.*

2. SpO2 with exercise on room air _____ %, **AND**

3. SpO2 _____ % on _____ LPM during exercise to show improvement

Physician Signature: _____ **Date:** _____