CONFIRMATION OF ORDER — Overnight Oximetry

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:** _____

Length of Need: 99 *(in months)*

Physician: _____ **NPI:** _____

DIAGNOSIS

ICD 10 Code	Description

EQUIPMENT/SERVICES

☐ Overnight Oximetry: ☐ Room Air ☐ On O2 at _____ LPM ☐ On PAP at _____ CmH2O

ADDITIONAL MEDICAL INFORMATION *(please read and check box before signing)*

☐ I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and available upon request.

Physician Signature: _____ **Date:** _____