BINSON'S Medical Equipment & Supplies Since 1953

Longwood, FL
Fax: 407-691-3021

BECN 15306034360

Clear Form

Oxygen Detailed Written Order Prior to Delivery

Patient Name: _____

Account #: _____ Patient DOB: _____

Patient Telephone Number: _____

☐ ***Face Sheet/Demographics Faxed***

Order Date _____

☐ ***Chart Notes Attached***
(Chart notes must include the need for the equipment being ordered)

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

DIAGNOSIS *(Check appropriate diagnosis below)* **Length of Need in Months** _____ **(99 = Lifetime)**

☐	Acidosis NOS Metabolic	☐	COPD	☐	Pulmonary Collapse Atelectasis
☐	Anomaly Lung - Chronic Bronchiectasis	☐	Emphysema	☐	Pulmonary Hypertension
☐	Bronchitis with COPD	☐	Hypoxemia	☐	Respiratory Failure
☐	CHF	☐	Lung DX NOS Chronic	☐	Other: _____

TREATMENT TYPE *(Check appropriate treatment type below)*

☐	24 - Hour Oxygen (Continuous)	☐	Portable (W/Activity)
☐	_____ LPM	☐	Pulse Flow Setting _____ Via Nasal Cannula
☐	Nocturnal Oxygen (At Night)	☐	Others: _____
☐	Overnight Oximetry	☐	Others: _____

EQUIPMENT *(Check equipment below)*

☐	**Concentrator (E1390)** (0 to 10 lpm continuous in home) 	☐	**Home Fill/Concentrator (K0738/E1390)** (Same as concentrator but can fill tanks for portability) 
☐	**Portable Concentrator –** Pull Behind (**E1392/E1390**) (0 to 3 lpm continuous/0 to 5 lpm pulse flow in home and portable 201 lbs) 	☐	**Portable Concentrator – Carry Style (E1392)** (0 to 5 lpm pulse flow portable 5lbs) 
☐	**Portable Tanks** (**E0431**) Only necessary if patient needs more than 3 lpm continuous for travel; must have chart notes prior to delivery.		
☐	**Other**: _____		

NECESSITY FOR OXYGEN (*Saturation test(s) must match saturation test(s) in chart notes)*

IF 88% BELOW: ONLY STEP 1 IS NEEDED	**IF 89% OR GREATER: STEP 2 &3 ARE NEEDED**
1. Oxygen Saturation Room Air at Rest Test _____ %	2. Oxygen Saturation Room Air Walking Test _____ %
	3. Oxygen Saturation on Oxygen @ _____ LPM Walking Test ___ %

Technician's Information

PRINTED Name _____ Test Date _____

Technician's Signature _____ Signature Date _____

Prescribing Physician's Information

Name & Credentials _____ NPI # _____

Telephone _____ Fax _____

Signature _____ Signature Date _____

(Stamped signature not accepted)

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If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 30 days prior to the date of order. This must be received by supplier before equipment is dispensed.

Home oxygen therapy may be payable only when the following criteria have been met:

The treating physician has determined the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with the oxygen ***and***,

The beneficiary's blood gas study meets the policy criteria ***and***,

The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services ***and***,

The qualifying blood gas study was obtained under the following conditions:

If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to but no earlier than two (2) days prior to the hospital discharge date ***or***,
If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state, not during a period of acute illness or an exacerbation of their underlying disease ***and***,
Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Medicare requires that a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart notes from the examination must be signed and dated by the author of the note.

For Portable Oxygen: The beneficiary must be tested at rest or during exercise/exertion. The beneficiary must be mobile within the home.

For Stationary Oxygen: The beneficiary may be tested at rest, during exercise/exertion or sleep.

When an exercise oximetry test is used to qualify the beneficiary (six (6) minute walk), there must be documentation of three (3) oximetry studies in the beneficiary's medical record.

- Testing at rest without oxygen
- Testing during exercise without oxygen and
- Testing during exercise with oxygen applied to demonstrate the improvement of the hypoxemia.

All oxygen qualification testing must be performed in person by a physician or other medical professional qualified to conduct oximetry testing (a provider who is qualified to bill Medicare for the test).

If the beneficiary has a diagnosis of Obstructive Sleep Apnea (OSA), the beneficiary will need to have a Titration study, a 6 minute walk, or a rest/awake test performed to qualify for the oxygen. A night pulse oximetry test will not meet Medicare's criteria for a qualifying test.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary.

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