AAA MEDICAL SOLUTIONS
Getting it done right...right now.

**Ph. 1.866.710.5779 Fx. 208.577.2893**
412 S. King Ave., Ste 100 Middleton, ID 83644

# OVERNIGHT OXIMETRY TESTING PRESCRIPTION

## PATIENT INFORMATION

PATIENT NAME:_____ DOB_____

PHONE: (_____)_____ SSN:_____ GENDER: ____M ____F

ADDRESS:_____ CITY, STATE, ZIP.:_____

**DME PROVIDER INFORMATION: NAME:**_____**PHONE:**_____

**CITY:**_____**ST:**_____**FAX:**_____

**NOTICE:** The DME Provider listed above is not affiliated with AAA Medical Solutions, Inc. The DME Provider will deliver the pulse oximeter testing equipment to the patient, retrieve the equipment and electronically transmit the data from the equipment to AAA Medical Solutions, Inc. Any questions related to your test or the use or operation of the pulse oximetry testing equipment should be directed to AAA Medical Solutions, Inc.

## PRESCRIPTION / DIAGNOSIS - TO BE COMPLETED BY THE PHYSICIAN

### DESCRIPTION OF SERVICES INCLUDED BY PRESCRIPTION:

☐ 94762 -- ON ROOM AIR ☐ 94762 -- ON O2 @ _____LPM ☐ 94762 -- ON CPAP / BIPAP

### DESCRIPTION OF SERVICES INCLUDED BY PRESCRIPTION:

☐ CHF ☐ COPD ☐ Dyspnea / Hypoxia ☐ Heart Failure Unspecified ☐ Emphysema ☐ SOB
☐ OSA ☐ Sleep Apnea ☐ Other Respiratory Abnormality:_____

## PHYSICIAN INFORMATION: * Required Field

PHYSICIAN NAME*:_____ NPI*:_____UPIN:_____

PHONE*: (_____)_____ FAX*: (_____)_____ E-MAIL:_____

ADDRESS*:_____CITY*:_____STATE*:_____ ZIP*:_____

## PHYSICIAN ATTESTATION AND SIGNATURE: * Required

I, the undersigned, certify that I am the treating physician as identified on this form. Any statement has been reviewed and signed by me. I certify that the information above is true, accurate and complete to the best of my knowledge, and understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

***PHYSICIAN SIGNATURE*** **X**:_____ Date:_____