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

DME / EQUIPMENT COURIER INFO

NAME:______________________________

CITY:________________________**ST:**______

PHONE: (_____)__________________

FAX: (_____)__________________

OVERNIGHT OXIMETRY TESTING PRESCRIPTION

PATIENT INFORMATION

PATIENT NAME:____ DOB_______________

PHONE: (________)____________________ SSN:__________________________ GENDER: ____M ____F

MAILING ADDRESS:____

CITY:______________________________STATE_______________ZIP.:______________________________

NOTICE: The DME Provider listed in the box at the top of this page is not afiliated 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

DIAGNOSIS OF MEDICAL NECESSITY:

☐ **780.57 Unspecified Sleep Apnea**	☐ **496 Chronic Airway Obstruction Not Elsew. Class.**
☐ **786.09 Respiratory Abnormality Other**	☐ **493.90 Asthma Unspecified**
☐ **416.0 Primary Pulmonary Hypertension**	☐ **428.0 Congestive Heart Failure Unspecified**
☐ 289.0 Polycythemia Secondary	☐ 493.20 Chronic Obstructive Asthma Unspecified
☐ 335.20 Amyotrophic Lateral Sclerosis	☐ 493.21 Chronic Obstructive Asthma With Status Asthmaticus
☐ 357.0 Acute Infective Polyneuritis	☐ 493.22 Chronic Obstructive Asthma With (Acute) Exacerbation
☐ 358.00 Myasthenia Gravis Without (Acute) Exacerbation	☐ 493.91 Asthma Unspecified Type With Status Asthmaticus
☐ 358.01 Myasthenia Gravis With (Acute) Exacerbation	☐ 493.92 Asthma Unspecified With (Acute) Exacerbation
☐ 416.2 Chronic Pulmonary Embolism	☐ 516.3 Idiopathic Fibrosing Alveolitis
☐ 492.8 Other Emphysema	☐ 517.2 Lung Involvement In Systemic Sclerosis
☐ 493.00 Extrinsic Asthma Unspecified	☐ 518.81 Acute Respiratory Failure
☐ 493.01 Extrinsic Asthma With Status Asthmaticus	☐ 780.51 Insomnia With Sleep Apnea, Unspecified
☐ 493.02 Extrinsic Asthma With (Acute) Exacerbation	☐ 780.53 Hypersomnia With Sleep Apnea, Unspecified
☐ 493.10 Intrinsic Asthma Unspecified	☐ 493.11 Intrinsic Asthma With Status Asthmaticus
	☐ 493.12 Intrinsic Asthma With (Acute) Exacerbation

INSURANCE PRE-AUTHORIZATION NUMBER:____

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:_____________