APRIA®

Oximetry Testing Order Form

Fax completed form to: 888.492.0010

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name _____ DOB _____
LAST FIRST

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

☐ Existing Apria oxygen patient ☐ Existing Apria PAP patient ☐ Existing Apria nebulizer patient

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's chart notes. Please check the appropriate qualifying diagnosis and write in the code. Ranges will not be accepted.

☐ _____ Chronic Obstructive Pulmonary Disease (J44.0–J44.9)
☐ _____ Emphysema (J43.0 – J43.9)
☐ _____ Chronic Bronchitis (J41.0 – J42)
☐ _____ Chronic Obstructive Asthma (J44.9)
☐ _____ Other Chronic Lung Conditions
☐ _____ Congestive Heart Failure (I50.20 – I50.43)
caused by _____ Cor Pulmonale (I27.81)
☐ _____ Unspecified Sleep Apnea (G47.30)

Please note that the patient cannot be in an acute state. Patient must be tested in a chronic stable state.

Overnight oximetry testing performed:

☐ on room air
☐ on prescribed oxygen
☐ on CPAP/Bi-level*
☐ on non-invasive ventilation

If oxygen is ultimately ordered, all Medicare documentation and testing requirements must be met.

*For patients on CPAP/Bi-level, overnight oximetry testing cannot be used to qualify a patient for oxygen. Testing must be performed during a facility-based sleep study.

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____