HomeFill System with Portable Oxygen Cylinders Form

Fax completed form to: _____

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 _____

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

Code _____ Description _____

Estimated length of need: _____ months (99 = lifetime) **Is the patient mobile at home?** ☐ Yes ☐ No

Please set up the above-named patient on an Oxygen Concentrator HomeFill System with Portable Oxygen Cylinders.

Please complete ONLY ONE OPTION below by checking the box and providing the appropriate settings.

EQUIPMENT ORDERED (May ONLY select one option)

OPTION 1

☐ Set up the above-named patient on the following:

- HomeFill System with Portable Oxygen Cylinders and an **Oxygen Conserving Device** (K0738)
- Oxygen Concentrator (E1390)

Settings provided below.

Oxygen at _____ LPM via Oxygen Concentrator

Oxygen Conserving Devices do not deliver liters per minute. Please prescribe a setting:

☐ Oxygen Conserving Device at setting (1 – 6) _____ ; or

☐ Titrate the Oxygen Conserving Device setting to achieve an SpO_2 of ≥ 90% (or _____%) at rest and during activities of daily living via pulse oximetry.

OPTION 2

☐ Set up the above-named patient on the following:

- HomeFill System with **Continuous Flow** Portable Oxygen Cylinders (K0738)
- Oxygen Concentrator (E1390)

Settings provided below:

Oxygen at _____ LPM at rest

Oxygen at _____ LPM with ambulation

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** _____

ACIS ID _____ CPU _____

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