847-824-0500 phone * PULMONARY PROVIDERS GROUP, INC. *847/824/0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Oxygen Dispensing Order Form

Referral Source:________________________________ Referral Source Phone:(________)____________________

Today's Date:_____/_____/_________ Date Patient was seen:_____/_____/________

PATIENT INFORMATION

Last Name:____________________________________ First Name:______________________________________

Address: ____

City:____ State: Illinois Zip code:____________________

Phone Number: (_______)______________________

Sex: Female___________ Male____________ Birth Date:______/______/___________

Height:__________ Weight:__________

DIAGNOSIS INFORMATION

Primary :____

Secondary:____

INSURANCE INFORMATION

Medicaid Recipient Number:____

Private Insurance Name:____ Policy:______________________________

PRODUCT(S) REQUESTED

[ ] Concentrator Test Date:____/____/______; was patient ambulated: [ ] Yes, [ ] No

[ ] Portable tanks Liter Flow: [ ] 1LPM; [ ] 2LPM; [ ] 3LPM; [ ] 4LPM; [ ] other________LPM

[ ] Carrier for Tank Continueous Flow: [ ] Yes, [ ] No Pulse Dose: [ ] Yes, [ ] No

[ ] Conserving device O2 Saturation: ______Room Air (rest); _______Ambulation; _______Recovery on O2

Required liter flow duration

[ ] LPM 24hrs/day [ ] LPM W/Ambulation [ ] LPM Nocturnal

Length of Need:_____________ (1-99 months) 99=lifetime (requires sleep study)

PHYICIAN INFORMATION

Name:____

Address:____

City:________________________________ State:________________________________ Zip code:____________________

Phone Number:(_______)______________________________

NPI:____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:____ Date:________/_______/____________