BINSON'S Medical Equipment & Supplies Since 1953

FAX BACK TO:
Michigan Fax: 1-586-755-2322
Florida Fax: 1-407-691-3021
Indiana Fax: 1-574-365-6202

BECN 15279010510

Reset Form

OXYGEN - Detailed Written Order Before Delivery

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

*****MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY**
Reason for Medical Necessity (other than diagnosis):
_____

DIAGNOSIS **Length of Need** _____ **(99 = Lifetime)**

- ☐ CHF
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Hypertension
- ☐ Respiratory Failure
- ☐ Other _____

QUALIFYING TEST

O2 @ Rest _____% O2 w/activity _____% O2 w/activity on _____ LPM _____%

TESTING

☐ Overnight Oximetry

TREATMENT TYPE (Check appropriate treatment below) _____LPM

- ☐ **E1390/E1392** 24-Hour Oxygen (continuous)
- ☐ **E1390** Nocturnal Oxygen (at night)
- ☐ **E0431** Portable Oxygen Tanks
- ☐ **E1392** Portable (w/activity)
  Pulse Flow (Conserving Device) Setting _____ Via Nasal Cannula
- ☐ Other _____

SPECIAL INSTRUCTIONS

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Date _____
(Stamped Signature Not Accepted)