Hayat
Home Medical Equipment

OXYGEN INTAKE / PRESCRIPTION FORM

Home Oxygen Equipment & Documentation Request

1. CUSTOMER / PATIENT INFORMATION

Name: _____	**Date of Birth:** _____
Phone: _____	**Address:** _____

2. INSURANCE / BILLING INFORMATION

Primary Insurance: _____	**Member / ID #:** _____
Group #: _____	**Policy Holder:** _____
[ ] Medicare **Medicare ID:** _____	[ ] Medicaid **Medicaid ID:** _____
Secondary Insurance: _____	**Secondary ID #:** _____

3. PHYSICIAN INFORMATION

Physician Name: _____	**NPI:** _____
Office Address: _____ _____	
Office Phone: _____	**Office Fax:** _____
Specialty: _____ _____	

4. HOME OXYGEN ORDER INFORMATION

Diagnosis Code: _____	**Diagnosis / Clinical Reason:** _____
Diagnosis Code: _____	**Diagnosis / Clinical Reason:** _____

Equipment needed — select all that apply:

[ ] Home stationary concentrator	[ ] Portable oxygen unit / POC	[ ] Oxygen tanks	[ ] POC evaluation needed

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5. OXYGEN TESTING / O2 SATURATION

At rest O2 saturation: _____ %	**With exercise:** _____ %
During sleep / overnight: _____ %	**Test date:** _____
Blood gas study date / result: _____	
6-Minute Walk Test date / result: _____	

6. PRESCRIBED OXYGEN USE

Method: [ ] Nasal cannula [ ] Mask	**Flow rate:** _____ LPM
Frequency: [ ] Nightly [ ] Continuous [ ] At night only	**Length of need:** _____ months (99 = lifetime)
Delivery: [ ] Stationary concentrator [ ] Portable O2 [ ] Tanks [ ] POC	

7. DOCUMENTATION TO BE FAXED WITH THIS PRESCRIPTION

Please fax the following to Hayat Home Medical Equipment with the completed prescription/order:

[ ] Most recent physician / clinical notes supporting the need for oxygen.

[ ] 6-Minute Walk Test (6MWT) results, including oxygen saturation and applicable oxygen requirement.

[ ] Relevant oxygen testing results (rest, exercise, and/or sleep, as applicable).

[ ] Blood gas study, pulse oximetry test, or other applicable qualification results.

8. PHYSICIAN CERTIFICATION

I certify that the information provided above is accurate and that the prescribed home oxygen equipment and supplies are medically necessary.

Physician Signature: _____

Printed Name: _____ **Date:** _____

NPI: _____ **Phone:** _____

FAX TO: 708-422-5966 | Hayat Home Medical Equipment | 3518 W 95th St, Evergreen Park, IL 60805 | TEL: 708-422-2300 Ext. 131