



Overnight Oximetry Request
Prescription Order Form

Phone: (352) 293-2810

Nationwide CMS Approved Independent Diagnostic Testing Facility

Fax: (352) 274-9122

Patient Information

Patient Name: _____ Male Female DOB: _____

Address: _____ City/State/Zip: _____

Phone: _____ Alt Phone: _____ Email: _____

Primary Ins: Medicare Medicaid Commercial Plan: _____ ID#: _____

Secondary Ins: Medicare Medicaid Commercial Plan: _____ ID#: _____

Please fax insurance cards along with completed paperwork for ALL Non-Medicare Patients.

Local DME Supplier: _____ Contact: _____

Phone: _____ Fax: _____ Email: _____

Ordering Physician: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

Patient Diagnosis – One Must be Checked

- 428.0 (CHF) 780.57 (Unspecified SA) 786.09 (Resp. Abnormality) 493.00 (Asthma – Unspec.)
- 496 (COPD) 493.92 (Asthma – Acute) 391.8 (Heart Disease Other) 428.9 (Heart Failure-Unspec.)
- 786.05 (SOB) 780.51 (Insomnia w/ SA) 780.53 (Hypersomnia w/ SA) Other:
- 515 (Pulm. Fibrosis) 492.8 (Emphysema – Other) 492.0 (Emphysematous Bleb)

Diagnostic Orders & Physician Certification

Overnight Oximetry (CPT Code: 94762) to be performed on:

- Room Air Oxygen at _____ LPM CPAP/BiPAP/APAP CPAP/BiPAP w/ Oxygen at _____ LPM

By signing below, I certify that I am ordering an overnight pulse oximetry (94762) for this patient listed on this prescription. The DME/HME company shall courier the pulse oximeter and process the data electronically through the IDTF listed above.

Physician Signature: **X** _____ Date: _____

Physician once signed, fax this form to the DME Courier at:

DME Courier, please fax this form BEFORE DELIVERING the pulse oximeter to your patient!