FORT Advantage Care
RESPIRATORY AND MEDICAL EQUIPMENT

Oxygen Therapy

Written Order Prior to Delivery (WOPD)

Fort Medical Equipment, LLC
306 Washington Street
Fort Atkinson, WI 53538-1741
Phone: 920-568-9860
Fax: 872-469-1691

Order Date: _____

Patient Name: _____ **Home Phone:** _____

Date of Birth: _____ **Cell Phone:** _____

Diagnosis: 1 _____ 2 _____ 3 _____

Duration: ☐ Lifetime (99) ☐ Other _____ months

Indicate prescribed liter flow, method of administration, and usage:

O2 @ _____ **LPM** _____ **via** _____

(indicate liter flow)	*(select usage)*	*(select method)*
	_____hours/day	Nasal Cannula
	continuous	O2 Mask- Indicate Oxygen Mask style
	Nocturnal use only	PAP mask
		Trach Collar or Adapter

Check one of the following selections:

☐ **Nocturnal Use Only**

Oxygen Concentrator - stationary unit (E1390) with Backup Tank System
A portable system is not covered when oxygen is prescribed for Nocturnal use.

☐ **Concentrator and Portable Oxygen Tank System with OCD Evaluation**

Oxygen Concentrator - stationary unit (E1390), Tanks and Regulator (E0431 & E0443)
Patient must be mobile within the home in order to qualify for a portable oxygen system.

OCD - Clinically indicated for oxygen liter flow from 1 - 3.
Evaluation of my patient by a Respiratory Therapist to qualify for the OCD. Respiratory Therapist may titrate patient prescribed oxygen setting to achieve an SpO2 of ≥ 90% at rest and during exercise /activities of daily living. I authorize patient be set up on the appropriate OCD of choice or qualification, which may include, oxymizer conserving pendant, conserving regulator, or portable oxygen concentrator.

Initial delivery of the portable system is a standard regulator with E-tanks. If the patient meets the OCD liter flow criteria, an evaluation will be scheduled with a Respiratory Therapist. Portable Oxygen Concentrators are only available on a private pay basis.

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, OXYGEN SATURATION TESTING, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes, Face to Face, and testing.

The following Medicare guidelines and must be met for the home oxygen therapy to be covered and deemed reasonable and medically necessary.

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, AND
2. The beneficiary's oxygen saturation testing was at 88% or less on room air , AND
3. The qualifying blood gas study was obtained within 2 days of discharge from a hospital or within 30 days from an outpatient visit, nursing facility, or overnight oximetry, AND
4. The testing was performed by a physician or by a qualified provider, AND
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.