Reliable RESPIRATORY

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Oxygen Prescription

All MASSHEALTH orders must be on ordering doctor's letterhead

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

Oxygen Testing Results: Must be <89% to qualify patient	
1. Oxygen for daytime use ☐ O2 Concentrator Continuous **(E1390)** via Nasal Cannula with Portable System **(E0431)** LPM: _____ ☐ O2 Concentrator Continuous **(E1390)** with Portable Gaseous Refill System **(K0738)** via Nasal Cannula LPM: _____ ☐ Test for Oxygen Conserving Device ☐ O2 Concentrator Continuous **(E1390)** with Portable O2 Concentrator **(E1392)** via Nasal Cannula LPM: _____	**2. Oxygen for nocturnal use** ☐ Concentrator **(E1390)** via Nasal Cannula LPM: _____ ☐ Bleed Oxygen **(E1390)** into PAP or Vent LPM via mask: _____

Overnight Oximetry: ☐ On Room Air ☐ On PAP/Vent ☐ On Oxygen LPM: _____

Frequency: ☐ 24 hours ☐ With exertion ☐ Nocturnal

Diagnosis: _____

Length of Need: ☐ Lifetime/99 years ☐ Other _____

Healthcare Provider Information

Healthcare Provider Name: _____ NPI: _____

Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Email: _____

Notes: _____

Healthcare Provider Signature: _____ **Date:** _____

***Please sign and fax to* (781) 987-8206**

Call* (781) 501-9072 *or email* support@reliablerespiratory.com *with any questions or concerns