Local Respiratory Provider – Oximetry Courier

_____

_____

_____

Phone: _____

Fax: _____

VO2 Order Form

Prescription and Clinical Evaluation

Customer Support: (877) 337-7111
Web: www.virtuox.net

Patient Information:

Name: _____ Gender: _____ DOB: _____
First Last

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Insurance: ☐ Check here if self-pay

Primary Payer: _____ ID#: _____ Group#: _____ Phone: _____

Secondary Payer: _____ ID#: _____ Group#: _____ Phone: _____

Prescriber Information:

Name: _____ NPI: _____
First Last

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

Phone: _____ Fax: _____

Diagnostic Order:

Overnight Oximetry / Awake Oximetry: Immediately and repeat in ☐ 30 ☐ 60 ☐ 90 ☐ Other ____ days to validate oxygen settings.

Test Condition:

☐ Room Air ☐ Oxygen: _____ ☐ APAP / CPAP / BIPAP: _____ ☐ Dental Device ☐ Other: _____

Diagnostic Codes: (Check all ICD-10 codes that apply)

Respiratory Related Codes

___	C34.90	Malignant neoplasm of unspecified part of bronchus or lung
___	J44.9	Chronic obstructive pulmonary disease, unspecified
	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
___	J43.9	Emphysema Unspecified
	J45.20	Mild intermittent asthma, uncomplicated
___	J45.22	Mild intermittent asthma with status asthmaticus
	J45.21	Mild intermittent asthma with (acute) exacerbation
___	J45.909	Unspecified asthma, uncomplicated
	J47.9	Bronchiectasis, uncomplicated
___	J47.1	Bronchiectasis with (acute) exacerbation
___	J84.10	Post Inflammatory Pulmonary Fibrosis
___	J96.00	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
___	R40.0	Somnolence
___	R40.1	Stupor
___	R06.02	Shortness of Breath
	R06.82	Tachypnea / Rapid Breathing
___	R06.2	Wheezing
	R06.00	Dyspnea
___	R06.83	Snoring
	R09.01	Asphyxia
___	R09.02	Hypoxia / Hypoxemia

Sleep Related Codes

___	G47.30	Apnea, Unspecified
___	G47.30	Hypersomnia with Sleep Apnea, Unspecified
	G47.30	Insomnia with Sleep Apnea, Unspecified
___	R09.02	Hypoxemia
___	G47.30	Sleep Apnea, Unspecified
___	G47.33	Sleep Apnea, Adult Pediatric

Cardiac Related Codes

___	I50.30	Unspecified diastolic (congestive) heart failure
___	I50.31	Acute diastolic (congestive) heart failure
	I50.32	Chronic diastolic (congestive) heart failure
___	I50.33	Acute on chronic diastolic (congestive) heart failure
___	I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
___	I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
___	I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
___	I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
___	I50.9	Heart failure, unspecified
___	I01.8	Other acute rheumatic heart disease
___	I09.81	Rheumatic Heart Failure (congestive)
___	I27.0	Primary Pulmonary Hypertension
___	I27.89	Other specified pulmonary heart disease
___	I27.9	Pulmonary Heart Disease, Unspecified
___	I50.9	Congestive Heart Failure, Unspecified
___	I50.1	Left Heart Failure
	I50.20	Unspecified systolic (congestive) heart failure
___	I50.21	Acute systolic (congestive) heart failure
___	I50.22	Chronic systolic (congestive) heart failure
___	I50.23	Acute on chronic systolic (congestive) heart failure

____ **Other:** _____

*** Date Patient Last Seen:** _____ /_____ /_____

My signature below certifies that the named patient above is having an awake / overnight oximetry to determine if the patient desaturates while sleeping, and or qualifies for home nocturnal oxygen.

Physician Signature: _____ **Date:** _____

Please fax completed order form & insurance card back to (800) 566-1959

Rev. 09/2021