Doctor Name: _____

Doctor Address/City/Zip: _____

Doctor Phone Number: _____ Fax Number: _____

Doctor License: _____ Doctor NPI: _____

CUSTOMER INFORMATION

Name: _____ Telephone: _____ Email: _____

Address/City/Zip: _____

DOB: _____ Diagnosis: _____ Ht: _____ Wt: _____ Male / Female

Insurance Name: _____ Network (back of card): _____

Common Networks: MultiPlan, Beech Street

ID #: _____ Group #: _____

RESPIRATORY (OXYGEN/NEBULIZERS)

☐ Oxygen @ ____LPM via nasal cannula ◯ Continuous/ ◯ Nocturnal only

☐ Oxygen Assessment (Nocturnal only) ☐ Portable Oxygen @ ____LPM with conserving device

****NOTE: PLEASE PROVIDE ANY OXYGEN TEST RESULTS**

☐ Nebulizer w/neb cup Medications:_____ Frequency:_____

☐ Nebulizer mask

CPAP/BIPAP/SLEEP STUDY

☐ SLEEP STUDY ☐ CPAP ☐ BI-LEVEL ☐ BI-LEVEL W/BACKUP RATE

☐ HEATED HUMIDIFIER

Indicate Settings:_____

Also includes: Mask, Headgear, Tubing, Disposable filters, Non-Disposable filters, Nasal Pillows, Chin Strap, Full Face Mask

****NOTE: PROVIDE COMPLETE SLEEP STUDY INCLUDING TITRATION STUDY, IF YOU WOULD LIKE US TO COURTESY BILL YOUR INSURANCE**

HOME MEDICAL EQUIPMENT ORDERED

- ☐ Walker (◯ FWW ◯ W/Seat)
- ☐ Cane (◯ Quad ◯ Straight)
- ☐ Wheelchair (Lightweight)
- ☐ Wheelchair (Standard Weight)
- ☐ Wheelchair (Electric Powered)
- ☐ Transport Chair
- ☐ Elevating Leg Rests
- ☐ Seat/Back Wheelchair Cushion
- ☐ Power Scooter
- ☐ Home Safety Evaluation
- ☐ Hospital Bed (Semi-Electric)
- ☐ Gel Mattress Overlay
- ☐ Low Airloss Mattress
- ☐ 3-in-1 Commode
- ☐ Shower Chair (◯ with back ◯ without back)
- ☐ Raised Toilet Seat

Date Needed: _____ **Length of Need**: _____

Physician Signature: _____ **Date:** _____

☐ Patient has been informed to expect a call from AirCare Home Medical

FAX To (866) 416-0058 or Email To: customer_service@aircaremedical.com