

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

- | | |
|--|---|
| <input type="checkbox"/> Walker (<input type="checkbox"/> FWW <input type="checkbox"/> W/Seat) | <input type="checkbox"/> Power Scooter |
| <input type="checkbox"/> Cane (<input type="checkbox"/> Quad <input type="checkbox"/> Straight) | <input type="checkbox"/> Home Safety Evaluation |
| <input type="checkbox"/> Wheelchair (Lightweight) | <input type="checkbox"/> Hospital Bed (Semi-Electric) |
| <input type="checkbox"/> Wheelchair (Standard Weight) | <input type="checkbox"/> Gel Mattress Overlay |
| <input type="checkbox"/> Wheelchair (Electric Powered) | <input type="checkbox"/> Low Airloss Mattress |
| <input type="checkbox"/> Transport Chair | <input type="checkbox"/> 3-in-1 Commode |
| <input type="checkbox"/> Elevating Leg Rests | <input type="checkbox"/> Shower Chair (<input type="checkbox"/> with back <input type="checkbox"/> without back) |
| <input type="checkbox"/> Seat/Back Wheelchair Cushion | <input type="checkbox"/> 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