

State of Vermont
Department of Vermont Health Access
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Agency of Human Services

Prescription for Pulse Oximeters-all ages

Please give this completed form to the patient or send directly to the DME supplier. DO NOT send to the Office of Vermont Health Access or to HP. Thank you.

Section I: Prescribing Provider

Date of Request ____/____/____

Check one: ____ Initial request ____ Renewal ____ Rental Only ____ Purchase

Patient Name _____

Medicaid ID _____ DOB ____/____/____

Pulse Oximeter Requested:

____ *Continuous w/24hr trending memory OR

____ *Continuous (non-hospital grade) alarms, memory print-out, ac/dc OR

____ Spot check only:

**Usually rental only*

Medical Necessity: *Attached supporting medical documentation.*

Estimate the length of time oximeter will be needed: Less than 3mos ____ 6mos ____ 12mos ____

Greater than 12 months __ if so please explain: _____

Describe treatment plan: _____

Please explain why this model is the only model that will meet the needs of this patient at this time: _____

Has the caregiver been trained on how to use the pulse oximeter, interpret the readings and actions to take? Yes ____ No ____



Section II: Provider Information

Requesting physician's specialty: _____

Physician's name: _____

VT. Medicaid Provider Number _____ NPI Provider No. _____

Physician's address: _____

Telephone _____ Fax _____

I certify that the item prescribed above is a *medically necessary* part of the course of treatment and is neither for *precautionary or 'standby' purposes nor for care giver convenience.*

Physician's signature _____ Date: ____/____/____

Section III: DME Provider

Information on equipment being placed in home (if new) or already in home (if renewal):

Brand: _____ Model: _____

Model #: _____ Serial #: _____

Warranty: Yes ___ No ___ Terms: 90 day ___ 1-Year ___ 2-Year ___ 3-Year ___ Other ____ (specify)

Date Caregiver trained by Respiratory Therapist: ____/____/____

Name and credentials: _____

Date equipment last maintained: ____/____/____

Date Respiratory Therapist last visited home: ____/____/____

Procedure Code: _____ Date of Service ____/____/____ to ____/____/____

I certify that the above described equipment is appropriate for the needs of the beneficiary as scripted out by the physician *and* is consistent with Vermont Medicaid's criteria for oximeters.

Supplier/Vendor Name _____

Provider # _____

Address: _____

Telephone # _____ Fax # _____

DME Rep Name (print) _____

DME Rep Signature: _____ Date: ____/____/____

Note: All records are subject to retrospective review by the Department of Vermont Health Access.