

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

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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 Department 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 now:

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 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.