Tomorrow Health
Phone 1-844-402-4344
Fax 888-616-2361 | tomorrowhealth.com

◯ Standard Service (3-5 days) ◯ Expedited Service (1-3 days) ◯ Discharge Service
Date and time your patient will be discharged:

Oxygen Contents & Equipment

v4

1. Patient Information

First name*: _____ Last name*: _____

Address*: _____ City*: _____ State*: _____

Zip*: _____ Phone*: _____ Email: _____

Primary insurance carrier*: _____ Primary insurance member ID*: _____

Secondary insurance carrier: _____ Secondary insurance member ID: _____

Date of birth*: _____ Sex*: _____ Height: _____ Weight: _____

2. Clinical Details

Frequency of use: _____ **Length of need:** _____

Diagnosis 1 (ICD-10)*:

◯ COPD (J44.9) ◯ SOB (R06.2) ◯ CHF (I50.20) ◯ ARDS (J80) ◯ Covid-19 Pneumonia (J12.81) ◯ Other: _____

Diagnosis 2 (ICD-10): _____

REQUIRED: 1) Attach chart notes 2) Attach SPO2 and input results below

Date of test*: _____ Oxygen saturation (room air): At rest: _____ While sleeping: _____ During exercise: _____

3. Product Selection

1. Select Item(s)

◯ Discharge kit: portable oxygen tanks and a stationary oxygen concentrator - E0431 + E1390

◯ Home oxygen with portability: portable tanks and a stationary oxygen concentrator - E0431 + E1390

- ◯ Please evaluate for portable oxygen concentrator - test for oxygen conserving device for a sat of 88% or greater

◯ Stationary oxygen concentrator only (for nocturnal use) - E1390

◯ Portable tanks only - E0431

◯ Portable oxygen concentrator - E1392

- ◯ Test for oxygen conserving device for a sat of 88% or greater
- ◯ Patient has already been evaluated, results are attached

◯ Portable and stationary concentrators - E1392 and E1390

- ◯ Test for oxygen conserving device for a sat of 88% or greater
- ◯ Patient has already been evaluated, results are attached

◯ Home fill system - K0738

◯ Medicaid / Managed Medicaid only: Pulse oximeter - E0445

◯ Nocturnal Oximetry Test: Please evaluate patient

2. If an existing oxygen patient, indicate order reason

☐ DME supplier change: _____ to _____

☐ Settings change: _____ LPM to _____ LPM

☐ Equipment change: _____ to _____

☐ Other: _____

ADD-ONS:

☐ Oxygen conserving device - A9900

- ☐ Test for oxygen conserving device for a sat of 88% or greater

☐ Humidifier - E0555

☐ Extended tubing - A4616

☐ Oxymizer - E1353

Flow rate: _____ LPM ◯ Continuous ◯ Pulse **via** ◯ Nasal cannula ◯ Mask ◯ Trach mask ◯ Bleed in w/ PAP device

5. Notes

6. Referring Provider Information

Name of person filling out form if other than physician: _____ Phone*: _____

Referring provider name*: _____ NPI*: _____ Date*: _____

Referring provider signature*:

I certify that I am the treating physician identified in this form. I have received the above sections of this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact in this document may subject me to civil or criminal liability.

INTERNAL USE ONLY | TH rep sign here

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