AAA MEDICAL SOLUTIONS
An Independent Diagnostic Testing Facility

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412 S. King Ave., Ste 100 Middleton, ID 83644
www.idtf.com

DME / EQUIPMENT COURIER INFO

NAME:_____
CITY:_____**ST:**_____
PHONE: (_____)_____
FAX: (_____)_____

OVERNIGHT OXIMETRY TESTING PRESCRIPTION

PATIENT INFORMATION

PATIENT NAME:_____ DOB_____
PHONE: (_____)_____ SSN:_____ GENDER: ____M ____F
MAILING ADDRESS:_____
CITY:_____STATE_____ZIP.:_____

NOTICE: The DME Provider listed in the box at the top of this page is not affiliated with AAA Medical Solutions, Inc. The DME Provider will deliver the pulse oximeter testing equipment to the patient, retrieve the equipment and electronically transmit the data from the equipment to AAA Medical Solutions, Inc. Any questions related to your test or the use or operation of the pulse oximetry testing equipment should be directed to AAA Medical Solutions, Inc.

PRESCRIPTION / DIAGNOSIS - TO BE COMPLETED BY THE PHYSICIAN

DESCRIPTION OF SERVICES INCLUDED BY PRESCRIPTION:

☐ 94762 -- ON ROOM AIR ☐ 94762 -- ON O2 @ _____LPM ☐ 94762 -- ON CPAP / BIPAP

DIAGNOSIS OF MEDICAL NECESSITY:

☐ 327.23 Obstructive Sleep Apnea
☐ 786.05 Shortness of Breath
☐ 780.79 Fatigue
☐ 780.57 Unspecified Sleep Apnea
☐ 780.53 Hypersomnia With Sleep Apnea
☐ 780.51 Insomnia With Sleep Apnea
☐ 799.02 Hypoxemia
☐ 786.09 Respiratory Abnormality Other
☐ Other:_____

☐ 496 Chronic Airway Obstruction (COPD)
☐ 493.90 Asthma Unspecified
☐ 493.20 Chronic Obstructive Asthma Unspecified
☐ 492.8 Emphysema
☐ 491 Chronic Bronchitis
☐ 428.0 Congestive Heart Failure Unspecified
☐ 416.0 Primary Pulmonary Hypertension

INSURANCE PRE-AUTHORIZATION NUMBER:_____

PHYSICIAN INFORMATION: * Required Field

PHYSICIAN NAME*:_____ NPI*:_____UPIN:_____
PHONE*: (_____)_____ FAX*: (_____)_____ E-MAIL:_____
ADDRESS*:_____CITY*:_____STATE*:_____ ZIP*:_____

PHYSICIAN ATTESTATION AND SIGNATURE: * Required

I, the undersigned, certify that I am the treating physician as identified on this form. Any statement has been reviewed and signed by me. I certify that the information above is true, accurate and complete to the best of my knowledge, and understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN SIGNATURE X:_____ Date:_____