

National Diagnostic Services, LLC.
110 W. Reynolds St, Suite 105
Plant City, FL 33563
Phone: 877-582-0202 Fax: 866-636-0202

Overnight Oximetry Testing Prescription

Patient Intake Information

Patient Name: _____ DOB: _____

Address: _____ City / St / Zip: _____

Phone: _____ SSN: _____ Gender: M: F:

DME Provider Information: Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

NOTICE: The DME provider listed above is not affiliated with diagnostic medical testing. The DME provider will deliver the pulse oximetry testing equipment to the patient, retrieve the equipment and electronically transmit the data from the equipment to National Diagnostic Services. Any questions related to the use or operation of the pulse oximetry testing equipment or your test should be directed to National Diagnostic Services.

Prescription / Diagnosis To Be Completed By The Physician

Description of Services Included by Physician:

94762 - On Room Air 94762- On O2 @ _____LPM 94762- On Cpap/ Bipap

Diagnosis (Please check all the apply):

CHF COPD Dyspnea/Hypoxia Heart Failure Unspecified Emphysema SOB OSA
 Sleep Apnea Respiratory Abnormality Other: _____

Physician Attestation and Signature / Date

I 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 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.

X

Physician Signature

Date

Physician's Name Printed: _____

NPI #: _____ Fax #: _____

UPIN #: _____ Phone #: _____

Address: _____

City / State / Zip: _____

Please fax completed prescription to: 877-582-0202

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Patient Verbal Order Information

Patient Name: _____ DOB: _____

Address: _____ City / St / Zip: _____

Phone: _____ SSN: _____ Gender: M: F:

DME Provider Information: Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

Insurance Information

Primary Insurance:

Medicare Medicare Number: _____

Medicaid Medicaid Number: _____ State: _____

Medicare Policy Number: _____ Group #: _____

Insurance Name: _____ Phone: _____

Address: _____ City / State / Zip: _____

Insured Person: _____ Self: Spouse: Child: Other:

Assignment of Benefits / Statement of Authenticity Required

I, the undersigned, hereby authorize payment be made on my behalf to the organization list at the top of this page for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claim or any part of them are denied payment. I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and services received.

I, the undersigned, also certify that I am the recipient of the oximetry testing unit and that the test was actually performed on me at the date and times specified below. I also certify that I have not, nor has the the courier of this test tampered with or altered this test in any way and that it will be downloaded in its original form.

Test Done on: <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <input type="checkbox"/> Cpap/ Bipap	Test Started: Date: _____ Time: _____	Test Ended: Date: _____ Time: _____
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Patient Signature: _____ Date: _____

Medical Release

I, the undersigned, authorized the organization at the top of the page to use and disclose my health information for the purpose of treatment obtaining payment, or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to any ordering physician and the DME provider listed above. (Note: You may call us using the number above if you would like to review our Notice of Privacy Practices before signing below.)

Patient Signature: _____ Date: _____