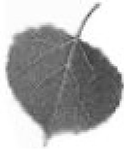

Aspen Medical Monitoring
7111 Zenobia St. Westminster, CO 80030
Tel: (800) 653-7015 Fax: (303) 962-9979

OVERNIGHT OXIMETRY TESTING PRESCRIPTION

PATIENT INFORMATION

PATIENT NAME: ______________________ DOB: __________

ADDRESS: ______________________________

PHONE: ______________ SSN: __________ GENDER: M: ☐ F: ☐

DME PROVIDER: NAME: ______________________ PHONE: __________

CITY: ______________ ST: ____ FAX: __________

NOTICE: THE DME PROVIDER LISTED ABOVE IS NOT AFFILIATED WITH ASPEN MEDICAL MONITORING. 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 ASPEN MEDICAL MONITORING. ANY QUESTIONS RELATED TO THE USE OR OPERATION OF THE PULSE OXIMETRY TESTING EQUIPMENT OR YOUR TEST SHOULD BE DIRECTED TO ASPEN MEDICAL MONITORING.

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 (PLEASE CHECK ALL THAT APPLY):

☐ 428.0 CHF ☐ 780.51 INSOMNIA WITH SLEEP APNIA

☐ 496 COPD ☐ 780.53 HYPERSOMNIA WITH SLEEP APNIA ☐ 780.57 OTHER UNSPECIFIED SLEEP APNIA

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 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.

X PHYSICIAN'S SIGNATURE: ______________________ DATE: __________

PHYSICIAN'S NAME PRINTED: ______________________________

NPI #: ______________________ FAX: ______________________

UPIN #: ______________________ PHONE: ______________________

ADDRESS: ______________________________

CITY / STATE / ZIP: ______________________________

PLEASE FAX COMPLETED PRESCRIPTION TO: ☐