Oxygen Prescription

MICHIGAN MEDICAL EQUIPMENT, INC. since 1984

11918 Farmington Rd
Livonia, MI 48150
Phone: (734) 522-8531
Fax: (734) 522-6846

Physician: _____
Address: _____

Beneficiary: _____
Address: _____

Insurance ID: _____
DOB: _____

THE INSURANCE COMPANY REQUIRES ALL OF THE FOLLOWING INFORMATION TO BE SUPPLIED BY THE ORDERING PHYSICIAN:

Durable Medical Equipment

Check box for requested equipment

Oxygen Concentrator - Stationary		Oxygen Homefill System w/ Portable Tanks	

Beneficiary Diagnosis **(ICD-10 REQUIRED)**: _____

Oxygen Flow Rate: _____

Estimated Frequency or Duration of Use **(PRN or "as needed" cannot be used)**: _____

Estimate Duration of Need: _____

Qualifying Test Results **(within 30 days of Initial Date)**: _____

Last Face-To-Face Appointment with Physician **(within 30 days of prescribing Oxygen)**: _____

Initial Date This Equipment Was Prescribed: _____

Physician NPI: _____

Physician Signature (not stamped): _____

Date Signed: _____