



# Order for Overnight Pulse Oximetry

Independent Diagnostic Testing Facility (IDTF)  
Instant Diagnostic Systems, Inc.  
1740 4th Ave, Suite A, Decatur, AL 35601 Ph. 800-355-0691

Form OX2010.01.20

## 1. Patient: \* Indicates required fields.

\*Last Name: \_\_\_\_\_ \*First: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\*Phone : (    ) \_\_\_\_\_ Alt Ph: (    ) \_\_\_\_\_

\*Birth Date: \_\_\_\_\_  Male  Female

## 2. Insurance: To help avoid billing issues, please check the primary insurance type and follow additional instructions.

- Medicare: Enter Medicare ID #:** \_\_\_\_\_ Or attach copy of Medicare Card
- Medicare Replacement / Medicaid / Other Gov. Plans:** Attach copy of front and back of insurance card.
- Commercial/Private:** Attach copy of front / back of insurance card.
- No Insurance/Self Pay**

## 3. Ordering Physician:

NPI: \_\_\_\_\_

\*\*\*Physician (or P.A. / N.P) ONLY must complete Step 4 - 5 - 6 \*\*\*

## 4. Procedure: OVERNIGHT PULSE-OXIMETRY RECORDING (CPT 94762)

"ON ROOM AIR"- unless checked:  On oxygen at \_\_\_\_ lpm  On CPAP at \_\_\_\_ cm/H2O  Test on BIPAP

## 5. Diagnosis: \*REQUIRED: At least one MUST be checked or written in.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> 416.0 Pulmonary Hypertension    | <input type="checkbox"/> 493.20 Chronic Obstr. Asthma | <input type="checkbox"/> 786.05 Shortness of Breath | <input type="checkbox"/> 327.23 Obstructive Sleep Apnea   |
| <input type="checkbox"/> 428.0 CHF                       | <input type="checkbox"/> 493.90 Asthma NOS            | <input type="checkbox"/> 786.09 Dyspnea             | <input type="checkbox"/> 780.51 Insomnia w/Sleep Apnea    |
| <input type="checkbox"/> 491.0 Simple Chronic Bronchitis | <input type="checkbox"/> 496. COPD                    | <input type="checkbox"/> 799.02 Hypoxemia           | <input type="checkbox"/> 780.53 Hypersomnia w/Sleep Apnea |
| <input type="checkbox"/> 492.8 Emphysema                 | <input type="checkbox"/> 780.79 Malaise / Fatigue     | <input type="checkbox"/> Other:                     | <input type="checkbox"/> 780.57 Sleep Apnea NOS           |

## 6. Physician Signature:

*I, the undersigned, authorize Instant Diagnostic Systems to perform an Overnight Oximetry Recording (and optionally a second follow-up test) on the patient listed above. IDS will bill Medicare, Medicaid, or other primary insurance for the cost of the test and collect patient responsibility accordingly. IDTF Regulations require that a written order be received by the IDTF prior to testing being performed.*

**Sign Here: X** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*Stamped signatures and dates are not accepted. Physician or PA / NP signatures only.**

Fax Form and Insurance Card to IDS (888) 771-5146