Home Medical Visits
Diagnostic Medical Testing
Patient's Are Our First Priority

PHYSICIAN ORDER FORM

TO: ATTENTION CLINICAL STAFF	FROM:	
COMPANY: HMV / DMT	PHONE #	FAX #
FAX NUMBER: 866-316-7824	DATE:	
PHONE NUMBER: 727-940-5908 or 877-202-1191	TOTAL NO. OF PAGES INCLUDING COVER: **Please forward a copy of the insurance card with order**	

~~ Please indicate Preferred DME Information ~~

DME: ______________________________ Phone # ______________________________

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CERT program (MAY INCLUDE SIMPLE STRESS TEST, CPAP COMPLIANCE, MDI/NEBULIZER MANAGEMENT, EQUIPMENT CHECKS, OVERNIGHT OXIMETRY AND DISEASE EDUCATION)

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_____ REST AND EXERTION/6 MIN. WALK

_____ OVERNIGHT OXIMETRY ON ROOM AIR AND CPAP

_____ OVERNIGHT OXIMETRY ON ROOM AIR

_____ Home Sleep Test (HST)

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Patient Name: ______________________________ Sex: ☐ M ☐ F DOB: ______________

Address: ______________________________ City: ______________

State: ______________ Zip: ______________ Phone: ______________

ICD-10 Coding REQUIRED: 1) _________ 2) _________ 3) _________ 4) _________ 5) _________

Patient Insurance Information

Primary Insurance: ______________________ ID#: ______________________

Address: ______________________ PH# ______________________

City: ______________ State: ______________ Zip: ______________

Secondary Ins: ______________________ ID# ______________________

Address: ______________________ PH#: ______________________

City: State: Zip:

Physician Name Printed: ______________________________

NPI: ______________________ Phone: ______________ Fax: ______________

Physician Signature: ______________________________ Date: ______________
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