



**Patient Referral Form for Hyperbaric Oxygen Therapy (HBOT)**

to be submitted by the referring physician – HCPCS G0277

**PATIENT INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**DIAGNOSIS(ES) and ICD-10 CODES ARE REQUIRED:**

<input type="checkbox"/> Diabetic Non-Healing Wound	ICD-10 code: E11.621
<input type="checkbox"/> Soft Tissue radionecrosis	ICD-10 code: L59.8
<input type="checkbox"/> Osteoradionecrosis	ICD-10 code: M27.2
<input type="checkbox"/> Prophylactic pre and post treatment for individuals undergoing dental surgery of a radiated jaw***	ICD-10 code: M27.2
<input type="checkbox"/> Chronic refractory osteomyelitis	ICD-10 code: M86.68
<input type="checkbox"/> Idiopathic Sudden Sensorineural Hearing Loss***	ICD-10 code: H91.21(R) H91.22 (L)
<input type="checkbox"/> Radiation Cystitis	ICD-10 code: N30.40
<input type="checkbox"/> Radiation Proctitis***	ICD-10 code: K62.7
<input type="checkbox"/> Preparation and/or preservation of compromised Skin Graft or Flap	ICD-10 code: T86.821
<input type="checkbox"/> Crush Injury	ICD-10 code:
<input type="checkbox"/> Other: _____	ICD-10 code:

\*\*\* NOT covered by Medicare

**PATIENT CLEARED FOR HYPERBARIC OXYGEN THERAPY BY PROVIDER:**

- ✓ Patients’ ears are clear
- ✓ Patients’ chest is clear
- ✓ Patient does not have a Pneumothorax or known lung issue
- ✓ Patient does not have a known contraindication for HBOT

Patient is APPROVED for HBOT per protocol. *Opt note* \_\_\_\_\_ OR

Patient is APPROVED for HBOT with the referring providers protocol as follows:

ATA : \_\_\_\_\_ PSI: \_\_\_\_\_

Minutes in HBOT chamber: 90mins or 60mins

# of treatments: \_\_\_\_\_ Days per week: 5 or \_\_\_\_\_

I have discussed the benefits and risks of Hyperbaric Oxygen Therapy (HBOT) with my patient.

**REFERRING PHYSICIAN’S SIGNATURE: Required** \_\_\_\_\_

Referring Providers name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

**Please fax the following to 480-590-6145. Please include Insurance Information, Face Sheet, H&P, Office Notes, Chest X-ray, Lab Work, Oncologist Note, Radiation Note, and Wound Care Notes**

Scottsdale Hyperbaric Center | 9923 E Bell Rd. #120, Scottsdale, AZ 85260

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