

**CERTIFICATE OF MEDICAL NECESSITY**

**OXYGEN**

**SECTION A Certification Type/Date: INITIAL** \_\_\_/\_\_\_/\_\_\_ **REVISED** \_\_\_/\_\_\_/\_\_\_ **RECERTIFICATION** \_\_\_/\_\_\_/\_\_\_

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER  (____) _____ - _____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER  (____) _____ - _____ NSC # _____	
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____	PT DOB ___/___/___; Sex ___ (M/F); HT. ___(in.); WT. ___(lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER  (____) _____ - _____ UPIN # _____	

**SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

**EST. LENGTH OF NEED (# OF MONTHS):** \_\_\_\_\_ 1-99 (99=LIFETIME) **DIAGNOSIS CODES (ICD-9):** \_\_\_\_\_

ANSWERS	ANSWER QUESTIONS 1-10. (Circle <b>Y</b> for Yes, <b>N</b> for No, or <b>D</b> for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____ % c) ___/___/___	1. Enter the result of most recent test taken <u>on or before</u> the certification date listed in Section A. Enter (a) arterial blood gas PO <sub>2</sub> and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed <b>EITHER</b> with the patient in a chronic stable state as an outpatient <b>OR</b> within <u>two</u> days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: _____ ADDRESS: _____
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are <u>not</u> ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a) _____ mm Hg b) _____ % c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test <u>taken on 4 LPM</u> . This may be an (a) arterial blood gas PO <sub>2</sub> and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

**IF PO<sub>2</sub> = 56-59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.**

Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):  
 NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**SECTION C Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

**SECTION D Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)