

Physician Signature

CERTIFICATE OF MEDICAL NECESSITY OXYGEN

SECTION A Certification Type/Date: INITIAL REV		REVISED RECERTIFICATION	
Patient Name		Supplier Name	
Address		Address	
Telephone ()		Telephone (
Member #		NCS or applicable NPI Number/Legacy Number	
	HCPCS Code	PT DOB Sex (M/F)	
Place of Service		Ht(in) Wt(lbs.)	
Name and Address of Facility if applicable		Physician Name	
Facility		Address	
Address			
		Telephone (
		NPI/Legacy Number	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies			
Est. Length of Need (# of months) 1-12 months Diagnosis Codes,,,			
Answers Answer Questions 1-8. Mark Y for Yes, N for No and D for Does Not Apply, unless otherwise noted.			
a) mm HG 1. Enter the result of n	1. Enter the result of most recent test taken on or before the certification dated listed in Section A.		
Enter:			
b) (a) Arterial blood ga	(a) Arterial blood gas PO2 (not required for children) and/or		
(b) oxygen saturation	(b) oxygen saturation test		
c) (c) enter date of tes	(c) enter date of test		
1 2 3 2. Was the test in ques	2. Was the test in question 1 performed either with the patient in a chronic stable state as an outpatient		
	OR within two days prior to discharge from an inpatient facility to home? 3= Other		
-	3 Mark the number for the condition of the test in question 1: (1) at rest (2) during exercise (3) during		
-	sleep.		
	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering		
, , , , , , , , ,	portable oxygen mark D.		
	5. Enter the highest oxygen flow rate ordered for the patient in liters per minute.		
	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM.		
This may be:	=		
b) (a) Arterial blood ga	(a) Arterial blood gas PO2 (not required for children) and/or		
(b) oxygen saturation	(b) oxygen saturation test with patient in a chronic stable state		
c) (c) enter date of test			
Answer questions 7-8 only if PO2 56-59 or Oxygen Saturation = 89% in Question 1			
Y N D 7. Does the patient have dependent edema due to congestive heart failure?			
Y N D 8. Does the patient ha	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an		
EKG or by an Echoca	EKG or by an Echocardiogram, gated blood pool scan, or direct pulmonary artery pressure		
measurement?	measurement?		
Name of person answering Section B questions, if	other than the phy	sician (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.			
SECTION D. DHYSICIAN Attactation and Signature / Data			
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.			

OHCA Revised 8-17-15 HCA-32

Date