Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
OXYGEN

SECTION A Certification Type/Date: INITIAL _____ REVISED _____ RECERTIFICATION _____

Patient Name _____ Address _____ _____ Telephone (____)_____-_____ Member # _____		Supplier Name_____ Address _____ _____ Telephone (____)_____-_____ NCS or applicable NPI Number/Legacy Number _____
Place of Service _____	HCPCS Code	PT DOB _____ Sex _____ (M/F) Ht. _____ (in) Wt. _____(lbs.)
Name and Address of Facility if applicable Facility _____ Address _____ _____	_____ _____ _____ _____	Physician Name _____ 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 b)_____ c)_____	1. Enter the result of most recent test taken on or before the certification dated listed in Section A. Enter: (a) Arterial blood gas PO2 (not required for children) and/or (b) oxygen saturation test (c) enter date of test
1 ☐ 2 ☐ 3 ☐	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
1 ☐ 2 ☐ 3 ☐	3. Mark the number for the condition of the test in question 1: (1) at rest (2) during exercise (3) during sleep.
Y ☐ N ☐ D ☐	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen mark D.
_____LPM	5. Enter the highest oxygen flow rate ordered for the patient in liters per minute.
a)_____mm HG b)_____ c)_____	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be: (a) Arterial blood gas PO2 (not required for children) and/or (b) oxygen saturation test with patient in a chronic stable state (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 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?

Name of person answering Section B questions, if other than the 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.

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 Signature _____Date _____