## **ACTION:** Final

## RESCINDED

## RESCINDED DATE: 12/20/2013 3:41 PM Ohio Department of Wedical Necessity/Prescription **OXYGEN SERVICES**

SECTION A: Consumer/Provider In	formati	0 <b>n</b>					
Certification Type:	🗌 Ini	itial	Revised		<b>Recertifica</b>	ation	
Consumer Name:				Provider's Name:			
Consumer DOB: Consumer Sex:			Consumer HT (in.): Consumer WT (lbs.):			Consumer WT (lbs.):	
Image: Female Male   (If consumer is not residing at home address) Prescriber's Name:							
(If consumer is not residing at nome address) Prescriber's Name:							
			Prescriber's NPI Number:				
Facility Address:			Prescriber's Telephone Number:				
Facility City, State and Zip Code: Prescriber's Medicaid Legacy							
SECTION B: Information below may not be completed by the provider of the Items/Supplies							
Est. Length of Need (# of Months): 1-99 (99= <b>LIFETIME</b> ):			Diagnosis Codes (ICD-9) and Descriptions:				
Last Medical Examination (MM/DD/YR):							
Results of Most Recent Arterial Blood Gas and/or Oxygen Saturation Tests (Patient Breathing Room Air) (All fields not required to be filled in.)							
1. At RestPO2:	O2 Saturation:	ation:			Date of Test:		
2. WalkingPO2:	O2 Saturation:	ation:			Date of Test:		
3. SleepingPO2: O2 Saturation:				Date of Test:			
4. ExercisingPO2: O2 Saturation:			Date of Test:				
5. Other: PO2: O2 Saturation:				Date of Test:			
6. RECERTS ONLY: Bleed in to CPAP or APAP (when used in lieu of CPAP):   Yes   No     Prescriber/Provider Performing Test:   Yes   Yes							
Name:   Address:     IF TESTS PERFORMED UNDER CONDITIONS OTHER THAN ROOM AIR, EXPLAIN:   If PO2 Level = 56-59 mm HG or the arterial blood saturation = 89% at rest on room air, it will be necessary to submit additional documentation supporting the need for Oxygen therapy. This documentation should be attached to this CMN and be on the letterhead of the prescriber.     Prescribed Oxygen Setting/ Flow Rates:   Continuous:   Yes   No     Noncontinuous (Enter hrs/day):   Walking:   Sleeping:   Exercise Program:   Other:     SECTION C:   Oxygen Equipment Prescribed   Delivery System:   Stationary Source   Supply System:							
Concentrator			Nasal Cannula				
Compressed Gas			O2 Conserving Device				
Liquid Oxygen			Pulse O2 System				
Other:			Reservoir System Other:				
Portable or Ambulatory Source     Liquid Oxygen   Is the consumer mobile within the home?     Compressed Gas   Yes     Other:				Other: Other:			
Does the consumer have dependent edema due to congestive heart failure?  Yes No							
Does the consumer have cor pumonale or pulmonary hypertension documented by P pulmonale on an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?							
Does the consumer have a hematocrit greater than 56%?							
I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability.							
Prescriber's Signature:					Date	:	

JFS 01909 (Rev. 6/2005)