

Ohio Department of Job and Family Services
 5101 North State Road
 Columbus, Ohio 43261-1093
Certificate of Medical Necessity/Prescription
OXYGEN SERVICES

SECTION A: Consumer/Provider Information

Certification Type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Recertification			
Consumer Name:		Provider's Name:	
Consumer DOB:	Consumer Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Consumer HT (in.):	Consumer WT (lbs.):
(If consumer is not residing at home address) Facility Name:		Prescriber's Name:	
Facility Address:		Prescriber's NPI Number:	
Facility City, State and Zip Code:		Prescriber's Telephone Number:	
		Prescriber's Medicaid Legacy Number:	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months): 1-99 (99=LIFETIME):	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 Rest.....PO2:	O2 Saturation:	Date of Test:
2. Walking.....PO2:	O2 Saturation:	Date of Test:
3. Sleeping.....PO2:	O2 Saturation:	Date of Test:
4. Exercising....PO2:	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): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prescriber/Provider Performing Test: Name: Address:		
IF TESTS PERFORMED UNDER CONDITIONS OTHER THAN ROOM AIR, EXPLAIN:		
NOTE: If PO2 Level exceeds 59 mm HG or the arterial blood saturation exceeds 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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Noncontinuous (Enter hrs/day):	Walking: Sleeping:	Exercise Program: Other:

SECTION C: Oxygen Equipment Prescribed

Supply System: Stationary Source <input type="checkbox"/> Concentrator <input type="checkbox"/> Compressed Gas <input type="checkbox"/> Liquid Oxygen <input type="checkbox"/> Other: _____ Portable or Ambulatory Source <input type="checkbox"/> Liquid Oxygen Is the consumer mobile within the home? <input type="checkbox"/> Compressed Gas <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	Delivery System: <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> O2 Conserving Device <input type="checkbox"/> Pulse O2 System <input type="checkbox"/> Reservoir System <input type="checkbox"/> Other: _____ <input type="checkbox"/> Transtracheal Catheter <input type="checkbox"/> Other: _____
Does the consumer have dependent edema due to congestive heart failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the consumer have cor pulmonale or pulmonary hypertension documented by P pulmonale on an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the consumer have a hematocrit greater than 56%? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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: