**Ohio Department of Job and Family Services**

**Certificate of Medical Necessity/Prescription**

# OXYGEN SERVICES

**SECTION A: Consumer/Provider Information**

| | | | |
|---|---|---|---|
| **Certification Type:** ☐ **Initial** ☐ **Revised** ☐ **Recertification** | | | |
| Consumer Name: | | Provider's Name: | |
| Consumer DOB: | Consumer Sex: ☐ Female ☐ Male | Consumer HT (in.): | Consumer WT (lbs.): |
| (If consumer is not residing at home address) Facility Name: | | Prescriber's Name: | |
| | | Prescriber's NPI Number: | |
| Facility Address: | | Prescriber's Telephone Number: | |
| Facility City, State and Zip Code: | | 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): ☐ Yes ☐ 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: ☐ Yes ☐ No |
| Noncontinuous (Enter hrs/day): Walking: Sleeping: Exercise Program: Other: | | |

**SECTION C: Oxygen Equipment Prescribed**

| | |
|---|---|
| Supply System:<br>Stationary Source<br>☐ Concentrator<br>☐ Compressed Gas<br>☐ Liquid Oxygen<br>☐ Other: _____<br><br>Portable or Ambulatory Source<br>☐ Liquid Oxygen Is the consumer mobile within the home?<br>☐ Compressed Gas ☐ Yes ☐ No<br>☐ Other: _____ | Delivery System:<br><br>☐ Nasal Cannula<br>☐ O2 Conserving Device<br>☐ Pulse O2 System<br>☐ Reservoir System<br>☐ Other: _____<br>☐ Transtracheal Catheter<br>☐ 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? ☐ Yes ☐ No | |
| Does the consumer have a hematocrit greater than 56%? ☐ Yes ☐ 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: |

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