RESCINDED

Al RESCINDED DATE: 12/20/2013 12:00 PM Onio Departmen Portodiand Family Services Certificate of Medical Necessity/Prescription **OXYGEN SERVICES**

Certification Type: Initial Revised Recertification Consumer Name: Provider's Name: Consumer WT (lbs.): Consumer WT (lbs.): Consumer Name: Male Consumer WT (lbs.): Consumer WT (lbs.): (If consumer Name: Prescriber's NEI Number: Prescriber's NEI Number: Prescriber's NEI Number: Facility Circ, State and Zip Code: Prescriber's Nei Number: Prescriber's Nei Number: Prescriber's Nei Number: Ext. Lengt of Nei (or Months): 1-99 Diagnosis Codes (GCD-9) and Descriptions: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen Saturation: Date of Test: Image: Status of Most Recent Arterial Blood Gas and/or Oxygen	SECTION A: Consumer/Provide	r Informa	tion							
Consumer DOR: Consumer Set: Consumer WT (lbs.): Consumer WT (lbs.): If consumer is not residing at home address) Prescriber's Name: Prescriber's Name: Facility Name: Prescriber's NPT Number: Prescriber's NPT Number: Facility CAdress: Prescriber's NPT Number: Prescriber's NPT Number: Facility CA, Sute and Zip Code: Prescriber's NPT Number: Prescriber's NPT Number: SECTION B: Information below may not be completed by the provider of the Items/Supplies Exc. Long to Number: Sec. Sec. Number: SECTION B: Information below may not be completed by the provider of the Items/Supplies Exc. Sec. Number: Sec. Sec. Number: Last Medical Examination (MM/DD/YR): Results of Most Recent Antenial Blood Gia and/or Oxygen Saturation: Date of Test: 3. A: Resc.: O2 Saturation: Date of Test: 3. 3. S. Weight S.: O2 Saturation: Date of Test: 3. S. Other: FO2: O2 Saturation: Date of Test: 3. S. Other: FO2: O2 Saturation: Date of Test: 3. S. Other: FO2: O2 Saturation: Date of Test: 3. S. Other: FO2: O2	Certification Type:		nitial		Revised			Recertifica	tion	
If oronumer is nersiding at home address) Prescriber's NRI Number: Encitity Name: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Exercise XII State and Zip Code: Prescriber's NRI Number: Facility City, State and Zip Code: Prescriber's NRI Number: Exercise XII State and Zip Code: Prescriber's NRI Number: Exercise XII State and Zip Code: Prescriber's NRI Number: Exercise XII State and Zip Code: Diagosis Codes (ICD-9) and Descriptions: (95: LINETNE): Q2 Saturation: Date of Test: 1. All RestPO2: Q2 Saturation: Date of Test: 2. WalkingPO2: Q2 Saturation: Date of Test: 3. SleepingPO2: Q2 Saturation: Date of Test: 4. ExercisingPO2: Q2 Saturation: Date of Test: 5. Other: PO2: Q2 Saturation: No Nome: Date of Test: No 6. RECERTS ONLY: Bleck in to CPAP	Consumer Name: Provider's Name:									
Facility Name: Prescriber's NPI Number: Facility Address: Prescriber's Telephone Number: SECTION B: Information below may not be completed by the provider of the Items/Supplies Fallary 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	Consumer DOB:								Consumer WT (lbs.):	
Prescriber's NPI Number: Facility Address: Prescriber's Telephone Number: Facility Address: Prescriber's Telephone Number: Facility Address: Prescriber's Stelephone Number: SECTION B: Information below may not be completed by the provider of the Items/Supplies Image: Complexity of the Items/Supplies Fat. langth of Need (#A Mowhis): 199 Disgnosis Codes (ICD-9) and Descriptions: Image: Complexity of the Items/Supplies Last Medical Examination (MM/DD/YR): Results of Most Recent Anterial Blood Gas and/or Oxygen Saturation Tests (Patient Breathing Room Air) (All fields nor required to be filled in.) 1. 1. At Rest	(If consumer is not residing at home address) Prescriber's Name:									
Facility City, State and Zip Code: Prescriber's Meliciaid Legacy Number: SECTION B: Information below may not be completed by the provider of the Items/Supplies Est. Length of Ned(# of Monthis): 1-99 (99-LIFETIME): Diagnosis Codes (ICD-9) and Descriptions: 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: O.2 Saturation: Date of Test: 2. WalkingPO2: O.2 Saturation: Date of Test: 3. SteepingPO2: O.2 Saturation: Date of Test: 4. ExercisingPO2: O.2 Saturation: Date of Test: 5. Other: PO2: O.2 Saturation: Date of Test: 6. RECERTS ONLY: Bleed in to CPAP or APAP (when used in lie u of CPAP): Yes No Prescriber/Provider Performing Test: Name: Address: No NTE: If PO2 Level = 56.59 mm HG or the arterial blood saturation = 89% at rest on room air, it will be necessary to subnit additional documentation sapporting the need for Oxygen Hempy. This documentation about be attached to this CHN and be on the letterelial of the prescriber. Stationary Source					Prescriber's NPI Number:					
SECTION B: Information below may not be completed by the provider of the Items/Supplies Ext. Length of Need (# of Months): 1-90 (09-LIFETIME): Diagnosis Codes (ICD-9) and Description: (09-LIFETIME): Last Medical Examination (IM/DD/TR): 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: Date of Test: 2. WalkingPO2: O2 Saturation: Date of Test: 3. SleepingPO2: O2 Saturation: Date of Test: 6. RECERTS ONLY: Bled in to CPAP or APAP (when used in lieu of CPAP): Yes No Prescriber/Provider Performing Test: Name: Address: Address: FTEST SPERFORMED UNDER CONDITIONS OTHER THAN ROOM AIR, EXPLAIN: NOTE: NOTE: 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 subprinting the ned for Oxygen heary. This documentation should be attached to this CKN and be on the letterhead of the prescriber. Seption: Continuous: Yes No Prescribed Oxygen Equipment Prescribed Supply System: Other: Other: Conpressed Gas Yes No Other: Other: Other: Other: <td colspan="3">Facility Address:</td> <td></td> <td colspan="5">Prescriber's Telephone Number:</td>	Facility Address:				Prescriber's Telephone Number:					
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: Date of Test: Last Medical Examination (MM/DD/YR): O2 Saturation: Date of Test: 2. WalkingPO2: O2 Saturation: 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: Name: Address: TTSTS PERFORMED UNDER CONDITIONS OTHER THAN ROOM AIR, EXPLAIN: NOTE: If PO2 Level = 56-59 mm HG or the arterial blood saturation = 599s 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. Prescribe/Provider Performing Test: Continuous: Yes No NOTE: If PO2 Level = 56-59 mm HG or the arterial blood saturation = 599s 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 p										
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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: Name: No Address: If TESTS PERFORMED UNDER CONDITIONS OTHER THAN ROOM AIR, EXPLAIN: No NOTE: If PO2 Level = 56-59 mm HG or the arterial blood saturation = 8% 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 SECTION C: Oxygen Equipment Prescribed Supply System: Other: Other: Stationary Source Delivery System: Nasal Cannula O2 Conserving Device Pulse O2 System Other:	2. WalkingPO2:	O2 Saturation:	Date			Date	e of Test:			
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Stationary Source Image: Nasal Cannula Concentrator Nasal Cannula Compressed Gas O2 Conserving Device Liquid Oxygen Pulse O2 System Other: Other: Portable or Ambulatory Source Other: Liquid Oxygen Is the consumer mobile within the home? Compressed Gas Yes Other: Other: Does the consumer have dependent edema due to congestive heart failure? Yes 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 Does the consumer have a hematocrit greater than 56%? Yes No Icertify 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.										
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Prescriber's Signature: Date:	attached documents signed and dated	by me, is tr								
	Prescriber's Signature:							Date:		

JFS 01909 (Rev. 6/2005)