U.S. Department of Health & Human Services
Health Care Financing Administration

Form Approved
DME No. 0938-0534
DMERC 484.2

Certificate of Medical Necessity

Oxygen

• SECTION A CERTIFICATION TYPE/DATE: INITIAL ___/___/___ REVISED ___/___/___

Patient Name, Address Phone #(__ __ __) __ __ __ - __ __ __ __ HICN________________________		Supplier Name, Address Phone #(_ _ _) __ __ __ - __ __ __ __ NSC# _______
Place of Service	HCPCS Code	PT DOB __/__/__ Sex ___ Ht___ (In) Wt___(Lbs)
Name, Address of Facility if applicable	____ ____ ____ ____	Physician Name, Address Phone #(_ _ _) __ __ __-__ __ __ __ UPIN#_________________

SECTION B INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES

Est. Length of Need (# of Months):___________ (00 – lifetime) | Diagnosis Codes (ICD-9): ______ ______ ______ ______

Answers	Answer Questions 1-10 (Circle Y for Yes, N for No or D for Does Not Apply, unless otherwise noted.)
a) __________ mm Hg b) __________ % c) ___/___/___	**1.** Enter the results of most recent test taken *on or before* the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	**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?
1 2 3	**3.** Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXX	**4.** Physician/provider performing test Question 1 (and if applicable, Question 7). Print/type name, address below: Name: Address
Y N D	**5.** If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen circle D.
___________ LPM	**6.** Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter X.
a)_________ mm Hg b)____________% c)____/____/____	**7.** If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state Enter date of test (c)
IF PO_2 = 56-59 OR OXYGEN SATURATION = 89% OR ABOVE, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.	
Y N D	**8.** Does the patient have dependent edema due to congestive heart failure?
Y N D	**9.** 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?
Y N D	**10.** Does the patient have a hematocrit greater than 56%?

Name of Person Answering Section B Questions, If Other Than 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 and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See Instructions on back)

• 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'S SIGNATURE____ DATE _____________ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)