State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

CERTIFICATE OF MEDICAL NECESSITY

OXYGEN			
SECTION A	**Certificate Type/Date: INITIAL _____ REVISED _____ RECERTIFICATION _____**		
PATIENT NAME:		SUPPLIER NAME:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
PT DOB _____ SEX _____ (M/F)		PRESCRIBER NAME:	
HEIGHT _____ (inches) WEIGHT _____ (lbs.)		ADDRESS:	
HCPCS Code: _____		PHONE NUMBER:	
		NPI # _____	

SECTION B	Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.
EST. LENGTH OF NEED (# OF MONTHS): _____ (Not to exceed 12)	DIAGNOSIS CODES: _____ _____
ANSWERS	ANSWER QUESTIONS 1-7 (Circle Y for Yes, N for No, unless otherwise noted)
_____	1. Enter the date of initial face-to-face evaluation.
(a)_____mm Hg (b)_____% (c)_____	2. Enter the result of recent test taken on or before the certification date listed in Section A. (a) arterial blood gas PO2 and/or (b) oxygen saturation test; and (c) date of test.
1 2 3	3. Was the test in Question 2 performed: (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
1 2 3	4. Circle the one number for the condition of the test in Question 2. (1) At Rest; (2) During Exercise; (3) During Sleep
Y N	5. If you are ordering portable oxygen, do the patient's activities take him/her beyond the functional limits of the stationary system?
_____LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".
(a)_____mm Hg (b)_____% (c)_____	7. If greater than 4 LPM is prescribed, enter results of recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient with patient in a chronic stable state. Enter date of test (c).
	ANSWER QUESTIONS 8 - 10 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 2
Y N	8. Does the patient have dependent edema due to congestive heart failure?

Y N	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	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

(1) Narrative description of all items, accessories and options ordered:

SECTION D — Physician Attestation and Signature/Date

I certify that I am the physician 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 any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: _____ DATE: _____
(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.)

Proof of Medical Necessity is valid for 12 months from the date of issue