

**COLORADO MEDICAID CERTIFICATE OF MEDICAL NECESSITY  
FOR OXYGEN BENEFITS\***

**SECTION A Certification Type/Date:** INITIAL \_\_\_/\_\_\_/\_\_\_ REVISED \_\_\_/\_\_\_/\_\_\_ RECERTIFICATION \_\_\_/\_\_\_/\_\_\_

|   |                  |  |               |
|---|------------------|--|---------------|
| PATIENT NAME, ADDRESS, TELEPHONE and MEDICAID ID<br><br>Medicaid # _____                      |                  | SUPPLIER NAME, ADDRESS, TELEPHONE AND PROVIDER ID#<br><br>Medicaid Provider ID # _____   |               |
| PLACE OF SERVICE _____  | HCPCS CODE _____ | PT DOB ___/___/___   | Sex ___ (M/F) |
| NAME and ADDRESS of FACILITY if residing in a nursing facility<br><br>_____<br>_____<br>_____ |                  | QUALIFIED PRACTITIONER NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN<br>(____) ____ - ____<br><br>UPIN or NPI # _____ |               |

**SECTION B Information in this section does not have to be completed by the Qualified Practitioner.**

EST. LENGTH OF NEED (# OF MONTHS): \_\_\_\_\_ 1-99 (99=LIFETIME)      DIAGNOSIS CODES (ICD-9): \_\_\_\_\_

|   |   |
|---|---|
| ANSWERS   | ANSWER QUESTIONS 1-8. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)  |
| a) _____ mm Hg<br>b) _____ %<br>c) ___/___/___  | 1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.  |
|   | 2.  |
| 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  |
| Y   N   D   | 4. If you are ordering portable oxygen, is the patient mobile within the residence or their mobile community? If you are not ordering portable oxygen, circle D.  |
| _____ LPM   | 5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".   |
| a) _____ mm Hg<br>b) _____ %<br>c) ___/___/___  | 6. 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 PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c). |
| <b>ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1</b> |   |
| Y      N  | 7. Does the patient have dependent edema due to congestive heart failure?   |
| Y      N  | 8. 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  | 9. Does the patient have a hematocrit greater than 56%?   |

**SECTION C Narrative Description of Equipment and Cost**

Narrative description of all items, accessories and options ordered

**SECTION D Qualified Licensed Practitioner Attestation and Signature/Date**

I certify that I am the qualified licensed practitioner who is responsible for the care of the patient 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.

QUALIFIED LICENSED PRACTITIONER \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_  
**Signature and Date Stamps Are Not Acceptable.**