DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

CERTIFICATE OF MEDICAL NECESSITY
CMS-484— OXYGEN

DME 484.5

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(___ ___) ___ ___-___ ___ ___ ___ Medicare ID	Procare Home Medical 4215 Credit Union Drive Anchorage, AK 99503 (9 0 7) 2 7 4 – 0 7 7 0 NSC or NPI # 1780625533

PLACE OF SERVICE 12	Supply Item/Service Procedure Code(s):	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___
NAME and ADDRESS of FACILITY if applicable (see reverse)	E1390 K0738	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NIP # (___ ___) ___ ___-___ ___ ___ ___ UPIN or NPI # ___

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Item Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1–99 (99=LIFETIME) | DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)___/___/___	1. Enter the result of 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.
❑1 ❑2 ❑3	2. Was the test in Question 1 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	3. Check 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 home? If you are not ordering portable oxygen, check D.
_____LPM	5. 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)___/___/___	6. 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 in a chronic stable state. Enter date of test (c).

ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1

❑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%?

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 option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)

HCPC	DESCRIPTION	QTY	FREQUENCY	CHARGE	ALLOWABLE
E1390	Concentrator	1	Monthly	$350.00	$134.71 _____ hrs/day
K0738	Homefill System	1	Monthly	$350.00	$ 44.32 ____lpm via _____

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.

Form CMS–484 (12/18)