

## CERTIFICATE OF MEDICAL NECESSITY CMS-484— OXYGEN

**DME 484.5**

<b>SECTION A: Certification Type/Date: INITIAL</b> ___/___/___ <b>REVISED</b> ___/___/___ <b>RECERTIFICATION</b> ___/___/___	
PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID  (____) _____ Medicare ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI # Procure 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 <u>12</u>	Supply Item/Service Procedure Code(s) _____
NAME and ADDRESS of FACILITY if applicable (see reverse)  E1390 E1392	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt. ___  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: _____
<b>ANSWERS</b>	<b>ANSWER QUESTIONS 1-9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)</b>	
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.	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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?	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	3. Check the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep	
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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**

<input type="checkbox"/> Y <input type="checkbox"/> N	7. Does the patient have dependent edema due to congestive heart failure?
<input type="checkbox"/> Y <input type="checkbox"/> 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.
<input type="checkbox"/> Y <input type="checkbox"/> 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	hrs/day
E1390	Concentrator	1	Monthly	\$350.00	\$134.71	_____
E1392	Portable Concentrator	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.