

**ALASKA MEDICAID
CERTIFICATE OF MEDICAL NECESSITY
HOME OXYGEN AND OXYGEN EQUIPMENT — 5-YEAR RUL REPLACEMENT AND RENEWAL**

This form is used to request replacement of home oxygen and oxygen equipment (oxygen equipment) at or after expiration of the 5-year Reasonable Useful Lifetime (RUL) and for renewal service authorizations following replacement. It serves as the certificate of medical necessity required for service authorization under 7 AAC 120.210. When all elements required under 7 AAC 120.200(t) are present, this form may also serve as the prescription order.

PURPOSE OF SUBMISSION

5-Year RUL Replacement Renewal (Post-Replacement)

SECTION A: MEMBER AND SUPPLIER INFORMATION

Member Name: _____ Date of Birth: _____

Member Medicaid ID: _____

Supplier Name: _____ Supplier Medicaid ID: _____

SUPPLIER ATTESTATION OF RUL REPLACEMENT ELIGIBILITY

Complete the following only if this submission is for a 5-Year RUL Replacement. The Supplier Representative Signature is required for all submissions.

- The original initial date of service for the member's current oxygen equipment is: _____
(MM/DD/YYYY)
- Sixty (60) or more months have elapsed since the original initial date of service.
- The member has elected to receive replacement oxygen equipment.

Supplier Representative Signature: _____ Date: _____

SECTION B: PRESCRIBER INFORMATION

No information in Sections B through D may be completed by the supplier.

Prescriber Name: _____ Prescriber Medicaid ID or NPI: _____

Prescriber Affiliation: _____

Date of Visit Addressing Oxygen: _____ Date of Face-to-Face Examination: _____

Requested Start Date: _____ Est. Length of Need: _____
(1-99 Months, 99 = lifetime)

Diagnosis Codes and Descriptions:

SECTION C: PRESCRIBER CERTIFICATION OF MEDICAL NECESSITY

The prescriber certifies the following based on clinical evaluation of the member:

- The member has a current medical need for home oxygen and oxygen equipment.
- The medical need is expected to continue: Indefinitely Estimated duration: _____ months
- The equipment identified in Section D is medically necessary for this member.

SECTION D: EQUIPMENT ORDER

Select the equipment to be furnished:

- Stationary Compressed Gas O2 Portable O2 Concentrator
- Stationary O2 Concentrator Home Fill Tank System
- Portable Gaseous O2

LPM (liters per minute): _____

Frequency of Use: _____ Quantity: _____

When all elements required under 7 AAC 120.200(t) are present on this form, it may serve as the prescription order. Required elements include: member name and date of birth (Section A); diagnosis and ICD code (Section B); item prescribed, quantity, and frequency of use (Section D); estimated length of need and requested start date (Section B); and prescriber signature and date (below).

A physician, physician assistant, or advanced practice registered nurse who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the member listed.

I hereby certify that I am the ordering prescriber identified in this form.

Prescriber Signature: _____ Date: _____

Printed Name and Title: _____

Instructions for Completion of the Home Oxygen 5-Year RUL Replacement and Renewal Certificate of Medical Necessity

Purpose of Submission

Check one box to indicate whether this CMN is being submitted for a 5-Year RUL Replacement (initial replacement of equipment at or after month 60) or a Renewal (renewal of a service authorization for an individual who has already undergone 5-year RUL replacement).

SECTION A: MEMBER AND SUPPLIER INFORMATION

Member Name — Enter the member's full name as it appears on their Medicaid identification.

Date of Birth — Enter the member's date of birth.

Member Medicaid ID — Enter the member's Alaska Medicaid identification number.

Supplier Name — Enter the name of the DMEPOS supplier submitting this request.

Supplier Medicaid ID — Enter the supplier's Alaska Medicaid identification number.

Supplier Attestation of RUL Replacement Eligibility

Complete only if the Purpose of Submission is 5-Year RUL Replacement. The supplier must complete all three attestation items based on supplier records. The original initial date of service is the date the member first received oxygen equipment under the current period of continuous use. The supplier must verify that 60 or more months have elapsed from that date before submitting this form, and must confirm that the member has elected to receive replacement equipment. For Renewal submissions, the attestation items should be left blank.

Supplier Representative Signature — Required for all submissions. The supplier's representative must sign and date, certifying the accuracy of the information provided in Section A.

SECTION B: PRESCRIBER INFORMATION

No information in Sections B through D may be completed by the supplier. All fields in these sections must be completed by the prescriber or the prescriber's clinical staff.

Prescriber Name — Enter the name of the prescribing physician, physician assistant, or advanced practice registered nurse.

Prescriber Medicaid ID or NPI — Enter the prescriber's Alaska Medicaid identification number or National Provider Identifier.

Prescriber Affiliation — Enter the name of the hospital, health professional group, clinic, or other organization with which the prescriber is affiliated.

Date of Visit Addressing Oxygen — Enter the date of the most recent clinical visit at which the member's oxygen needs were evaluated.

Date of Face-to-Face Examination — Enter the date of the face-to-face examination conducted under 7 AAC 120.200(s). This may be the same as the date of visit addressing oxygen. The examination must have occurred within six months prior to the requested start date.

Requested Start Date — Enter the date on which use of the equipment should begin.

Est. Length of Need — Enter the estimated duration of need in months (1–99). Enter 99 if the need is expected to continue for the member's lifetime.

Diagnosis Codes and Descriptions — Enter the ICD code and description for each diagnosis supporting the medical necessity of home oxygen equipment. Up to three diagnoses may be listed.

SECTION C: PRESCRIBER CERTIFICATION OF MEDICAL NECESSITY

The prescriber must check each applicable box to certify that the member has a current medical need for home oxygen equipment, that the need is expected to continue (indefinitely or for a stated duration), and that the equipment identified in Section D is medically necessary. These certifications are based on the prescriber's clinical evaluation of the member.

SECTION D: EQUIPMENT ORDER

The prescriber must select the oxygen equipment to be furnished by checking the appropriate box or boxes. Enter the prescribed liter flow rate (LPM), frequency of use, and quantity. Both stationary and portable equipment may be selected if medically necessary.

ATTESTATION AND PRESCRIBER SIGNATURE

The prescriber must review the attestation language, then sign and date the form. A printed name and title are also required. The signature certifies the accuracy of all information provided in Sections B through D and attests to the medical necessity of the prescribed equipment.

NOTE — PRESCRIPTION ORDER

When all elements required under 7 AAC 120.200(t) are present on the completed form, it may serve as both the certificate of medical necessity and the prescription order. A separate prescription is not required if the form includes: member name and date of birth (Section A); diagnosis and ICD code (Section B); item prescribed, quantity, and frequency of use (Section D); estimated length of need and requested start date (Section B); and prescriber signature and date.

Submit the completed form with a service authorization request to Durable Medical Equipment Service Authorization Requests using one of the options below. A completed *Home Oxygen and Oxygen Equipment – Supplier Page* must be submitted with the service authorization request.

Fax (toll-free): (888) 772-3632

Fax (local): (907) 644-8131

DSM: DmeSA@hms.fa.directak.net

Mail: Service Authorization

P.O. Box 240808

Anchorage, AK 99524-0808