ALASKA MEDICAID
CERTIFICATE OF MEDICAL NECESSITY
HOME OXYGEN AND OXYGEN EQUIPMENT for Members Aged 5 and Older.

SECTION A:

Member Name: _____ Supplier Name: _____

Member Medicaid ID:_____ Supplier Medicaid ID: _____

SECTION B: No information in the following sections (B through E) may be completed by the supplier.

Prescriber Name:_____ Diagnosis Codes and Descriptions:

Prescriber Medicaid ID or NPI: _____ _____ - _____

Date of visit addressing Oxygen: _____ _____ - _____

Requested start date:_____ _____ - _____

Est. Length of Need (1-99 Months, 99 = lifetime):_____ DOB _____ Sex_____ HT_____(in) WT_____ (lbs)

SECTION C: INITIAL REQUESTS Complete only if member is **AGED 5 OR OLDER**. If member is under the age of 5, use *Under 5 CMN* form. Answer the following based on the test(s) performed. See page 2 for specific criteria guidelines

Method of Testing: (check all that apply) **Results:**

☐ Taken at rest (awake) while breathing room air and/or _____ mm Hg or ____ %

☐ Take during exercise and/or _____ mm Hg or ____ %

☐ Taken during sleep Date of Test(s): _____ _____ mm Hg or ____ %

If all of the test results entered above are either an arterial PO2 of 56-59 mm Hg or an arterial O2 sat ≥ 89%, answer the questions below

a. Dependent edema suggesting congestive heart failure? a. Yes ☐ No ☐

b. Pulmonary hypertension or cor pulmonale determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG? b. Yes ☐ No ☐

c. Erythrocythemia with a hematocrit > 56%? c. Yes ☐ No ☐

If the answers to question 2 are all no, does the member have a medical condition with distinct physiologic, cognitive and/or functional symptoms which will improve with oxygen therapy? Yes ☐ No ☐

SECTION D: OXYGEN EQUIPMENT ORDER

☐ Stationary Compressed Gas O2 ☐ Portable Gaseous O2 _____ LPM

☐ Stationary O2 Concentrator ☐ Portable O2 Concentrator

☐ Home Fill Tank System _____ Frequency of use

A physician, physician assistant, nurse practitioner or specialist 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 patient listed. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

This must be signed by the specialist if any part of Section B through E is completed by someone other than the provider listed in Section B.

_____ _____

Name and Signature of Specialist, Title Date

I hereby certify that I am the ordering physician/physician assistant/nurse practitioner/specialist identified in this form.

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner/Specialist Date