ALASKA MEDICAID
CERTIFICATE OF MEDICAL NECESSITY
HOME OXYGEN AND OXYGEN EQUIPMENT for Member Under the Age of 5

SECTION A: Certification Type: INITIAL ☐ REVISED ☐ RENEWAL ☐

Member Name: _____ Supplier Name: _____

Member Medicaid ID: _____ Supplier Medicaid ID: _____

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

Prescriber Name: _____ Diagnosis Codes and Descriptions:

Prescriber NPI: _____ _____ - _____

Date of last visit that addressed oxygen: _____ _____ - _____

Requested start date: _____ _____ - _____

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

SECTION C: Complete this section for initial, revised, or renewal requests for members **UNDER THE AGE OF 5**.

C1.	Member has been diagnosed with a lung disease or hypoxia-related condition expected to improve with oxygen therapy.	Yes ☐	No ☐
C2.	Member is under the care of and followed by a pediatric pulmonologist or cardiologist.	Yes ☐	No ☐
C3.	Member is aged 1 or older, has O2 saturations ≤ 93% during 3 independent intermittent measurements for at least 5% of a continuous recording period which includes a period of sleep.	Yes ☐	No ☐
C4.	Member is aged under 1 year, has O2 saturations ≤ 90% during 3 independent intermittent measures of ≤ 90% for at least 5% of a continuous recording period which includes a period of sleep.	Yes ☐	No ☐

SECTION D: OXYGEN EQUIPMENT ORDER Choose the appropriate equipment for the member (under the age of 5).

D1. Member qualifies for **BOTH STATIONARY AND PORTABLE** home oxygen equipment with **Yes** answers to C1 and C2 and either C3 or C4.

Choose **ONE** stationary system and **ONE** portable system:

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

_____ LPM

_____
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 D 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

Medical records must support oxygen saturation determinations and the need for supplemental home oxygen and oxygen equipment. Medical records must be submitted if requested.