GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR OXYGEN EQUIPMENT

Estimated length of time oxygen needed: _____ months

Certification Type/Date: INITIAL _____/_____/_____ REVISED _____/_____/_____	
Members Name: _____	**Members Medicaid Number (Do Not List Mother's ID):** _____
Patient DOB_____/_____/_____ Sex_____ HT._____(in) WT._____(lbs.)	
Suppliers Name: _____ **Suppliers NPI Number:** _____	Suppliers Address and Telephone Number: _____ _____ _____
Physicians Name: _____ **Physicians NPI Number:** _____	Physicians Address and Telephone Number: _____ _____ _____
HCPCS Code(s)	
Place of Service	

Primary Diagnosis _____ ICD-10 Diagnosis Code_____

Must be respiratory or cardiac related

Secondary Diagnoses supporting medical necessity:

_____ ICD-10 Diagnosis Code(s)_____

Select equipment ordered (do not select more than one stationary or portable system):

Stationary System: ☐ Compressed Gas ☐ Liquid Oxygen ☐ Oxygen concentrator

Portable System: ☐ Compressed Gas ☐ Liquid oxygen

Liters per minute ordered: _____ **Hours per day ordered for use:** _____

Method of delivery (nasal cannula, mask, etc.)

_____

If portable oxygen prescribed, state purpose:

_____

Laboratory results:

ABG* (PO2 result) _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

Oxygen saturation* _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

*** Copy of laboratory report must be attached to PA request ***

If test not performed on room air, please explain:

_____

If ABG (PO2) exceeds 60 mmHg or if oxygen saturation exceeds 89% for ages 21 and over, justify need for oxygen with supporting clinical rationale supporting the medical need:

_____

_____

I certify that the oxygen equipment is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.