



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 <u>Not</u> 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: _____ _____ _____
HCPSC 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 ten (10) 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 304 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.