CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN
(To be completed by the licensed practitioner or by the provider based upon documentation of medical necessity by the licensed practitioner)

I certify that the information on this form is true and correct

Licensed Practitioner Signature:	Date:
Licensed Practitioner Name (please print):	Licensed Practitioner License Number:
Licensed Practitioner Address:	Licensed Practitioner Phone Number:
Patient Diagnosis (specific and complete, include any secondary diagnoses that relate to oxygen need):	

Patient Name:	Date of Birth:	Client Identification Number (CIN):
Provider Phone Number:	National Provider Identifier (NPI):	

Oxygen delivery system (type of equipment):

- ❑ Gaseous, stationary
- ❑ Gaseous, portable
- ❑ Liquid, stationary
- ❑ Liquid, portable
- ❑ Oxygen concentrator, stationary
- ❑ Oxygen concentrator, portable

If portable system is requested, describe activities of daily living/instrumental activities of daily living that cannot be performed using a stationary system:

- ❑ Date oxygen prescribed: _____
- ❑ Dates of service: _____
- ❑ Oxygen flow rate: _____
- ❑ Length of need: _____

Number of hours per day needed:

- ❑ Day-time: _____
- ❑ Night-time: _____
- ❑ Exertion: _____

Arterial blood gas on room air:
Date of test: _____ Test results: PaO2 _____ PaCO2 _____ pH _____
HCO3 _____ Sa02 _____
Oxygen saturation study on room air:
Date of test: _____ Test results: SaO2: _____

Activity level during blood gas study:

❑ Awake and at rest ❑ Exercising ❑ Asleep for at least 5 minutes

If authorization is to be based on an oxygen saturation study, please attach summary of protocol used and the oximetry graph(s).

If ABG or oxygen saturation study was not on room air, please explain why not:
Oxygen flow rate (including method of delivery) or oxygen concentration:
Name and address of testing facility:
Any additional medical findings supporting need for oxygen:
If equipment is not to be used in home, indicate facility name and address: