

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY: PULSE OXIMETERS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	
	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Applicable specifications — HCPCS code, description, make, model, serial number, accessories, etc.
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Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation	Prior PA number
<input type="checkbox"/> Rental of oximeter for ____ days (≤ 90), from ___/___/_____ to ___/___/_____		
<input type="checkbox"/> Purchase of oximeter		
<input type="checkbox"/> Payment for probes, supplies, and accessories (≤ 12 months)		
Diagnostic monitoring <input type="checkbox"/> This individual was currently being weaned or was about to be weaned from an oxygen supply. <input type="checkbox"/> This individual was oxygen-dependent and was in a clinically unstable condition. <input type="checkbox"/> Attached are previously recorded oximeter data. Assessment: _____	Continuous monitoring <input type="checkbox"/> This individual exhibits clinical instability (evidenced by chronically compromised respiration and frequently varying oxygen requirements). <input type="checkbox"/> This individual is at risk for critical fluctuations in oxygen saturation (e.g., hyperoxia, hypoxia). At least one of the following conditions is present: <input type="checkbox"/> Frequent bradycardia <input type="checkbox"/> Frequent oxygen desaturation <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Ventilator-dependency <input type="checkbox"/> Poor growth and development suggesting inadequate oxygenation <input type="checkbox"/> Another specific risk factor: _____	
<input type="checkbox"/> The following documentation is attached: _____		

Attestation [This section must be completed by the prescriber.]

<i>I hereby attest that the certification information above is true, correct, and complete.</i>	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.