Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: OXYGEN

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
	Telephone number	

NOTE: Prior authorization is required *unless* oxygen is being supplied to an individual who either (a) meets group I or group II criteria or (b) is a resident of a long-term care facility (LTCF).

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

☐ Initial	☐ Renewing	☐ Revised
Diagnosis code(s)	Date of evaluation	Prior PA number

Results of most recent blood gas study

At rest ..... PO2 _____ Saturation _____ Date ___/___/_____

Ambulating ..... PO2 _____ Saturation _____ Date ___/___/_____

Sleeping ..... PO2 _____ Saturation _____ Date ___/___/_____

[Other] _____ ..... PO2 _____ Saturation _____ Date ___/___/_____

Estimated length of need / Certification period

☐ Group I — 12 months

At rest: PO2 ≤ 55 mm Hg *or* saturation ≤ 88%

Ambulating: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% and documented improvement with oxygen

Sleeping: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% *or* PO2 decrease > 10 mm Hg *or* saturation decrease > 5%

☐ Group II — 3 months

PO2 56–59 mm Hg *or* saturation ≥ 89% and dependent edema, pulmonary hypertension or cor pulmonale, or hematocrit > 56%

☐ _____ month(s)

☐ Lifetime

Specifications

System: ☐ Stationary only ☐ Stationary/portable ☐ Supplementary portable

Flow rates: ☐ Continuous, ____ LPM ☐ Noncontinuous (____ hours/day)

Ambulating, ____ LPM

Sleeping, ____ LPM

[Other] _____, ____ LPM

Interface: ☐ Nasal cannula ☐ Mask ☐ Transtracheal catheter ☐ Positive airway pressure device

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

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

False certification constitutes Medicaid fraud.