



Please fax completed form to 303-785-9333

Date Faxed: \_\_\_\_\_

**COLORADO MEDICAID CERTIFICATE OF MEDICAL NECESSITY**

**FOR OXYGEN BENEFITS\***

\*RETAIN IN CLIENT'S FILE

**SECTION A Certification Type/Date:** INITIAL \_\_\_/\_\_\_/\_\_\_ REVISED \_\_\_/\_\_\_/\_\_\_ RECERTIFICATION \_\_\_/\_\_\_/\_\_\_

PATIENT NAME, ADDRESS, TELEPHONE and MEDICAID ID  
Patient's Name: \_\_\_\_\_  
Patient Address: Patient residing in a facility. Please refer to the facility's address below.  
Medicaid # \_\_\_\_\_

SUPPLIER NAME, ADDRESS, TELEPHONE AND PROVIDER ID#  
Schryver Medical Inc 12075 E 45<sup>th</sup> Ave Suite 600  
303-371-0073 Denver, CO 80239  
Medicaid Provider ID # \_\_\_\_\_

PLACE OF SERVICE \_\_\_\_\_ HCPCS CODE \_\_\_\_\_

PT DOB \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ (M/F)

NAME and ADDRESS of FACILITY if residing in a nursing facility  
Facility \_\_\_\_\_  
Address \_\_\_\_\_  
City CO 80202

QUALIFIED PRACTITIONER NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN  
(\_\_\_\_\_) - \_\_\_\_\_ UPIN or NPI # \_\_\_\_\_  
Ordering Doctor's Name: \_\_\_\_\_

**SECTION B Information in this section does not have to be completed by the Qualified Practitioner.**

EST. LENGTH OF NEED (# OF MONTHS): \_\_\_\_\_ 1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-9): \_\_\_\_\_

ANSWERS	ANSWER QUESTIONS 1-8. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____ % c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
	2.
<b>1 2 3</b>	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
<b>Y N D</b>	4. If you are ordering portable oxygen, is the patient mobile within the residence or their mobile community? If you are not ordering portable oxygen, circle D.
_____ LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a) _____ mm Hg b) _____ % c) ___/___/___	6. <b>If greater than 4 LPM</b> is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
<b>ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1</b>	
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N	9. Does the patient have a hematocrit greater than 56%?

**SECTION C Narrative Description of Equipment and Cost**

Narrative description of all items, accessories and options ordered (circle all that applies): \_\_\_\_\_ Cost: \_\_\_\_\_  
**Concentrator                      Liquid Portable                      Liquid Stationary**

**SECTION D Qualified Licensed Practitioner Attestation and Signature/Date**

I certify that I am the qualified licensed practitioner who is responsible for the care of the patient identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

QUALIFIED LICENSED PRACTITIONER \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_  
**Signature and Date Stamps Are Not Acceptable.**

**Reason for O2 Use/Symptom:** \_\_\_\_\_