

CERTIFICATE OF MEDICAL NECESSITY CMS-484 — OXYGEN

DME MAC 484.03

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ - _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (____) _____ - _____ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___/___/___ Sex ___ (M/F)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i>	_____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____) _____ - _____ UPIN or NPI # _____
SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1-9. (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 PO ₂ and/or (b) oxygen saturation test; (c) date of test.	
1 2 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?	
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep	
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? 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. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO ₂ and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).	
ANSWER QUESTIONS 7-9 ONLY IF PO₂ = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1		
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%?	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):		
NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)		
SECTION D Physician Attestation and Signature/Date		
I certify that I am the treating physician 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.		
PHYSICIAN'S SIGNATURE _____		DATE ___/___/___