

Certificate of Medical Necessity Form



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Oxygen - This CMN is not required with the claim. It is completed by the ordering physician and maintained in file by the oxygen provider.

Section 1

SECTION 1: CERTIFICATION DATE: INITIAL _____ / _____ / _____ REVISED _____ / _____ / _____

Patient Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ ID# _____

Supplier Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

Physician Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

PT DOB ____/____/____ SEX _____ (M/F) HEIGHT _____ WEIGHT _____

Section 2

SECTION 2: MEDICAL NECESSITY INFORMATION (Physician if this section is blank please complete)

Estimated length of need (# of months): _____
1 through 99 (99 = lifetime)

Covered Diagnoses for Stationary and Portable:

- a. Bronchiectasis
- b. Cancer
- c. CHF
- d. COPD
- e. Chronic Bronchitis
- f. Chronic Interstitial Pneumonia
- g. Cystic Fibrosis
- h. Emphysema
- i. Pulmonary Hypertension
- j. Pulmonary Fibrosis
- k. Secondary Polycythemia
- l. Sleep Apnea
- m. Other

Covered Diagnoses for Portable only:

- a. Cluster Headaches
- b. Migraine
- c. Other:

Enter the result of the most recent test taken ON or BEFORE the certification date listed in Section 1:

Lab report attached Results can be confirmed by: _____

Related to question directly above, check the appropriate box to the right:

Stationary oxygen flow rate prescribed
Portable oxygen flow rate prescribed (if different than stationary flow rate prescribed):

If ordering portable oxygen:

Arterial blood gas PO₂: _____% (60 PO₂)
Oxygen saturation test: _____% (89% or below)
Date of test: ____/____/____

- a. During normal activities of daily living (walking, sitting)
- b. During exercise therapy
- c. Other

_____ LPM _____ Hours per day
_____ LPM _____ Hours per day

- a. The patient is mobile beyond 50 feet of stationary system
- b. I have prescribed an exercise therapy program
- c. The patient suffers from cluster or migraine headaches
- d. Other: _____

SECTION 3: NARRATIVE DESCRIPTION OF EQUIPMENT

Check narrative description of equipment you are ordering:

- a. Liquid stationary
- b. Conserving device
- c. Concentrator
- d. Gaseous portable
- e. Liquid portable

SECTION 4: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the physician identified in Section A of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Physician's Signature

Date

Do not submit with claim, please retain in patient file for possible review in the future.