Certificate of Medical Necessity Form

Pulse Oximeter

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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)

Diagnosis codes (ICD-9): ________ - _____/

________ - _____/ ________ - _____/

________ - _____/ ________ - _____/

(Complete below and/or attach additional sheet if needed.)

Please give brief description of patient's prognosis. ____________________

____

Is the patient's condition considered ❑ Chronic ❑ Acute ____________________

____

List complicating factors that would substantiate medical necessity for the pulse oximeter. ____________________

____

In what way will treatment be changed based on the values obtained by use of the pulse oximeter: ____________________

____

Additional circumstances necessitating use of this equipment: ____________________

____

Please note: The use of the pulse oximeter in the home should be reassessed every 30 days, if rented. The assessment, by the physician, should indicate that the patient's care is being modified based on the use of the oximeter.

Section 3

SECTION 3: 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** ______ /______ /______

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