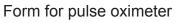
Certificate of Medical Necessity





Section 1A – Patient Information

First Name		MI	Address	;		
Last Name		Suffix	City			
Phone Number	ID Number		State	ZIP Code	+4	County
Date of Birth			Height	Weight		
Section 1B – Suppli	er Information					
Supplier Name			Address	;		
Phone Number	NPI Number		City			
			State	ZIP Code	+4	County
Section 1C – Physic	cian Information					
First Name		MI	Address	;		
Last Name		Suffix	City			
Phone Number	ID Number		State	ZIP Code	+4	County
Section 2 – Medical	Necessity Information					
Note: Physician, if this section is blank, please complete.		Diagnosis codes (ICD-10) – separate with a comma:				
Initial Certification Date	Revised Certificat	ion Date				
Estimated length of need 1 – 99 (99 = Lifetime)	d (number of months)					
Complete the questions	below (attach additional s	sheets if	needed):		
Please give a brief desc	ription of patient's progno	osis:				
Is the patient's condition	considered: 🗆 Chronic	Acu	ite			
List complicating factors	that would substantiate r	medical r	necessity	y for the pulse	oximeter:	

Section 2 – Medical Necessity Information (continued)

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 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

Physician's Signature (Signature and date stamps are not acceptable)

Date Signed