Indiana Health Coverage Programs
Medical Clearance Form

Certificate of Medical Necessity for Oxygen

Section A: Certification Type/Date: Initial _____ Revised _____ Recertification _____

Patient name Address Phone number _____ IHCP Member ID _____	Supplier name Address Phone number _____ IHCP Provider ID_____
Place of service _____ Name and address of facility if applicable *(see reverse)*	Supply item/service procedure code(s): _____ _____ _____ _____
PT DOB _____ Sex ___(M/F) Ht. _____(in) Wt. _____ Physician name Address Phone number _____ IHCP Provider ID_____	

Section B: Information in this section may not be completed by the supplier of the item supplies.

Estimated length of need (# of months): _____ 1–99 (99=lifetime) | Diagnosis code(s): _____ _____ _____ _____

Answer Questions 1–9. (Check Y for Yes, N for No, or N/A for Not Applicable, unless otherwise noted.)	**Answers**
1. Enter the result of 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.	a)_____mm Hg b)_____% c)_____
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. Check the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep	☐1 ☐2 ☐3
4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, check N/A.	☐Y ☐N ☐N/A
5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".	_____ LPM
6. If greater than 4 LPM is prescribed, enter results of 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; (c) date of test.	a)_____mm Hg b)_____% c)_____
Answer questions 7-9 only if PO2 = 56–59 or oxygen saturation = 89 in question 1	
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%?	☐Y ☐N

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; and (2) supplier's charges

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 _____
Signature and Date Stamps Are Not Acceptable.

Instructions for Completing the Certificate of Medical Necessity for Oxygen

SECTION A:	**(May be completed by the supplier)**
Certification type/date:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space Type/ marked "Initial." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "Initial," and indicate the recertification date in the space marked "Revised." If this is a recertification, indicate the initial date needed in the space marked "Initial," and indicate the recertification date in the space marked "Recertification." Whether submitting a Revised or a Recertified certificate of medical necessity, be sure to always furnish the Initial date as well as the Revised or Recertification date.
Patient information:	Indicate the patient's name, permanent legal address, telephone number and IHCP Member ID as it appears on their IHCP member card and on the claim form.
Supplier information:	Indicate the name of your company (supplier name), address and telephone number along with your IHCP Provider ID.
Place of service:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc.
Facility name:	If the place of service is a facility, indicate the name and complete address of the facility.
Supply item/service procedure code(s):	List all procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the certificate of medical necessity.
Patient DOB, height, weight and sex:	Indicate patient's date of birth (MM/DD/YY), sex (male or female), height in inches and weight in pounds, if requested.
Physician information:	Indicate the physician's name, complete mailing address, telephone number (where the physician can be contacted if more information is needed, preferably where records would be accessible pertaining to this patient) and IHCP Provider ID.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the certificate of medical necessity signed (in Section D) by the treating practitioner.)**
Estimated length of need:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of their life, then enter "99".
Diagnosis code(s):	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up 4 to codes).
Question section:	This section is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question that applies to the items ordered.
Name of person answering Section B questions:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, they must print their name, give their professional title and the name of their employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
Narrative description of equipment & cost:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; and (2) the supplier's charge for each item(s), options, accessories, supplies and drugs.
SECTION D:	**(To be completed by the physician)**
Physician attestation:	The physician's signature certifies (1) the certificate of medical necessity which they are reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
Physician signature and date:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the certificate of medical necessity in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.