DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY
CMS-484—OXYGEN

DME 484.03

SECTION A CERTIFICATION TYPE/DATE: INITIAL __/__/__ REVISED __/__/__ RECERTIFICATION __/__/__

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC OR APPLICABLE NPI NUMBER/LECACY NUMBER
(__ __ __) __ __ __-__ __ __ __ HICN ___________________________	(__ __ __) __ __ __-__ __ __ __ NSC OR NPI #_______________

PLACE OF SERVICE ______________	HCPCS CODE	PT DOB __/__/__ SEX M/F
NAME AND ADDRESS OF FACILITY (IF APPLICABLE – SEE REVERSE)	__________ __________ __________ __________	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	ANWSER 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) for arterial blood gas PO2 and/or (b) for oxygen saturation test, or (c) for 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, (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 an “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 PO2 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 and 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

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.)

SECTION D PHYSICIAN ATTESTATION AND SIGNATURE AND 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 Certification 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:_______________