Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: OXYGEN

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

NOTE: *Prior authorization is required unless oxygen is being supplied to an individual who either (a) meets group I or group II criteria or (b) is a resident of a long-term care facility (LTCF).*

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

☐ **Initial**	☐ **Renewing**	☐ **Revised**
Diagnosis code(s)	Date of evaluation	Prior PA number

Results of most recent blood gas study

At rest	PO2	Saturation	Date
Ambulating	PO2	Saturation	Date
Sleeping	PO2	Saturation	Date
Other	PO2	Saturation	Date

Estimated length of need / Certification period

☐ Group I — 12 months
At rest: PO2 ≤ 55 mm Hg *or* saturation ≤ 88%
Ambulating: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% and documented improvement with oxygen
Sleeping: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% *or* PO2 decrease > 10 mm Hg *or* saturation decrease > 5%

☐ Group II — 3 months
PO2 56–59 mm Hg *or* saturation ≥ 89% and dependent edema, pulmonary hypertension or cor pulmonale, or hematocrit > 56%

☐ month(s) [≤ 12]	☐ Lifetime

Specifications

System: ☐ Stationary only ☐ Stationary/portable ☐ Supplementary portable

Flow rates: ☐ Continuous, LPM ☐ Noncontinuous (hours/day)
Ambulating, LPM
Sleeping, LPM
[Other] , LPM

Interface: ☐ Nasal cannula ☐ Mask ☐ Transtracheal catheter ☐ Positive airway pressure device

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.