MEDICAID FORM
GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR OXYGEN EQUIPMENT

Estimated length of time oxygen needed: _____ months

Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____	
Members Name:	**Members Medicaid Number (Do Not List Mother's ID):**
Patient DOB ____/____/____ Sex _____ HT. _____ (in) WT. _____ (lbs.)	
Suppliers Name: Professional Medical HHC **Suppliers NPI Number:** 1942287131	**Suppliers Address and Telephone Number:** 4855 Memorial Drive Stone Mountain, GA 30083 404-292-9190
Physicians Name: **Physicians NPI Number:**	**Physicians Address and Telephone Number:**
HCPCS Code(s)	E1390, E0431
Place of Service	HOME (12)

Primary Diagnosis _____ ICD-10 Diagnosis Code_____
Must be respiratory or cardiac related

Secondary Diagnoses supporting medical necessity:
_____ ICD-10 Diagnosis Code(s)_____

Select equipment ordered (do not select more than one stationary or portable system):

Stationary System: ☐ Compressed Gas ☐ Liquid Oxygen ☐ Oxygen concentrator

Portable System: ☐ Compressed Gas ☐ Liquid oxygen

Liters per minute ordered: _____ **Hours per day ordered for use:** _____

Method of delivery (nasal cannula, mask, etc.)

_____

If portable oxygen prescribed, state purpose:

_____

Laboratory results:

ABG* (PO2 result) _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

Oxygen saturation* _____ ☐ Room Air ☐ Oxygen _____%. Date of test: _____

*** Copy of laboratory report must be attached to PA request ***

If test not performed on room air, please explain:

_____

If ABG (PO2) exceeds 60 mmHg or if oxygen saturation exceeds 89% for ages 21 and over, justify need for oxygen with supporting clinical rationale supporting the medical need:

_____

_____

I certify that the oxygen equipment is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation ____/____/____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____ Date____/____/____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.