APPENDIX Q

CERTIFICATION FOR OXYGEN

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number _____ Date of Birth _____

Member Full Name _____

Diagnosis* _____ **ICD-9 Code** _____

* Must be respiratory or cardiac related.

Prescription Information:

Date oxygen prescribed: _____ ☐ Initial ☐Renewal

Date last seen by physician: _____

Equipment prescribed: Stationary system: ☐ Compressed gas ☐ Liquid oxygen
☐ Oxygen concentrator
Portable system: ☐ Compressed gas ☐ Liquid oxygen

Liters per minute: _____ **Hours per day**: _____

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

If portable oxygen prescribed, state purpose: _____

Estimated length of time oxygen needed: _____ months

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 more medical information: _____

I CERTIFY THAT OXYGEN IS MEDICALLY NECESSARY:

Physician Signature * _____ Date _____

Physician's printed name _____

Address _____

***Stamped signatures or dates are not acceptable**