Diagnosis code and description.

Estimated length of need.

Results from the ABG PO₂ or saturation test. The test date should correspond with the applicable qualified test.

Test mode: Chronic/Inpatient/Other.

Test condition: Rest/Exercise/Sleep.

Patient mobile in home? When not ordering portable oxygen, D applies. Otherwise, the question is Yes or No.

Highest oxygen flow rate in Liters per Minute (LPM).

Information for Group II patients (if PO₂ = 56-59 mm Hg or O₂ sat = 89%).
Medicare Certificate of Medical Necessity

**SECTION A** Certification Type/Date:

- **INITIAL 07/15/12**
- **REVISED**
- **RECERTIFICATION**

**PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER**

- RICHARD THOMPSON
- AAJ354
- 123 TULIP DRIVE
- LAKE FOREST, CA 92630
- (855) 279-7889
- HCN: 123456789A

**SUPPLIER NAME, ADDRESS, TELEPHONE and NPI or applicable PNUMBER/legacy NUMBER**

- APRIA HEALTHCARE INC
- 26220 ENTERPRISE CT
- LAKE FOREST, CA 92630
- (949) 639-2000
- NPI or NPI#: 1123456789

**PLACE OF SERVICE**

- 12

**HCPCS CODE**

- PT DOB: 26/26/35
- Sex: M

**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**
  - **A.**
    - **a.** mm Hg
    - **b.** %
    - **c.** mm Hg

- **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?

- **3.** Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Excercise; (3) During Sleep

- **Y**

- **5.** Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a “X”.

- **a.** mm Hg
- **b.** %
- **c.** %

- **ANSWER QUESTIONS 7-8 ONLY IF PO2 = 56-69 OR OXYGEN SATURATION = 89 IN QUESTION 1**

- **7.** Does the patient have dependent edema due to congestive heart failure?

- **Y**

- **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**

- **9.** Does the patient have a hematocrit greater than 56%?

**NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Print):**

- **NAME:**
- **TITLE:**
- **EMPLOYER:**

**SECTION C** Narrative Description of Equipment and Cost

- **HCPCS DESCRIPTION**
  - E1390 OXYGEN CONCENTRATOR
  - E0431 PORTABLE GASEOUS OXYGEN SYSTEM; RENTAL

- **SUBMIT CHARGE**
  - AT REST
  - AT 24.00 Hrs/Day
  - $760.48
  - $176.06
  - $365.76
  - 29.43

- **MCR ALLOWABLE**
  - AT REST
  - AT 24.00 Hrs/Day
  - $176.06
  - $29.43

**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 this section may subject me to civil or criminal liability.

**PHYSICIAN’S SIGNATURE**

- **DATE**

*Reminders*

- Please remember that ALL cross-outs and/or overwrites MUST be initialed and dated by the physician. Do not use correction fluid or tape.
- Different color pens used to complete CMN may be construed by Medicare auditors as unauthorized corrections.
- Signature/date stamps are not allowed.
- Electronic signatures should be accompanied by a statement indicating that the signature was applied electronically (i.e., electronically signed by, authenticated by, digitally signed by, validated by, etc.).