



Prior Authorization Request
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ColoradoPAR Program
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Redical Review Department
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## QUESTIONNAIRE #16 OXYGEN CONTENTS IN EXCESS OF 6 LITERS PER MINUTE OVERNIGHT PORTABLE OXYGEN FOR MEMBERS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY

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Membe	r Name		Health First Colorado ID #								
Length of Need			Height			Weigl			ht		
Health First Colorado Provider ID				DME Suppl			ier Name			<u> </u>	
more th appropriand atta	nan 6 liters riate reimb ach to the	s per n oursen comp	IN EXCESS OF 6 LPI ninute (LPM) regularly nent for the oxygen co leted Prior Authorization	. The Intent on Re	informations informations in the description in the information in the	n requeste etermine m R).	d below is	s requ	ired to deter	mine	
1.	1. What is the complete diagnosis with complicating factors?										
2.	How many estimated monthly deliveries and pounds or cubic feet of oxygen are necessary to supply oxygen contents to the member?										
3.	What is the distance (in miles) from the supplier to the member's residence?							miles			
4.			the member start using on a regular basis?	g moi	re than 6 LI	PM of					
OVERNIGHT PORTABLE OXYGEN FOR MEMBERS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY											
5.		Identify the circumstances necessitating coverage for portable oxygen for a member for whom oxygen is necessary only at night.									
6.	Is the portable oxygen necessary for the member to receive medical treatment outside of their residence? <b>Note</b> : For either purpose, complete an oxygen medical necessity letter and attach.							; <u></u>	No		
7.	Supply ar	ny addi	tional information that v sity for this request:	will as	ssist us in d	etermining					
Print Pr	escriber N	lame _					ı				
Prescrib	oer Signati	ure									

