COLORADO
Department of Health Care Policy & Financing

Kepro

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #16
OXYGEN CONTENTS IN EXCESS OF 6 LITERS PER MINUTE OVERNIGHT PORTABLE OXYGEN FOR MEMBERS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY

Member Name		Health First Colorado ID #	

Length of Need		Height		Weight	
Health First Colorado Provider ID			DME Supplier Name		

OXYGEN CONTENTS IN EXCESS OF 6 LPM: This member was prescribed oxygen and is expected to use more than 6 liters per minute (LPM) regularly. The information requested below is required to determine appropriate reimbursement for the oxygen contents and to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

Question	Response
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. What month did the member start using more than 6 LPM of oxygen contents on a regular basis?	
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? **Note**: For either purpose, complete an oxygen medical necessity letter and attach.	☐ Yes ☐ No
7. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name ____

Prescriber Signature ____

Date ______________________________

Revised September 2021