Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
Fax: 1-866-940-4288

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

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
Medicaid Provider ID:		Weight:	
DME Supplier Name:			

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

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 client?	
3) What is the distance from the supplier to the client's residence? (in miles)	_____ miles
4) What month did the client start using in excess of 6 LPM of oxygen contents on a regular basis?	
OVERNIGHT PORTABLE OXYGEN FOR CLIENTS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY	
5) Identify the circumstances necessitating coverage for portable oxygen for a client for whom oxygen is necessary only at night.	
6) Is the portable oxygen necessary for the client to receive medical treatment outside of their residence? **<u>Note:</u> For either purpose, attach a copy of the Certificate of Medical Necessity for Oxygen.**	☐Yes ☐No
7) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

Print Prescriber Name _____

Prescriber Signature _____ Date _____

Revision Date: 09/15