COLORADO
Department of Health Care Policy & Financing

Kepro

HEALTH FIRST COLORADO CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN BENEFITS*

SECTION A - Certification Type/Date: INITIAL___/___/ REVISED___/___/___ RECERTIFICATION___/___/

MEMBER NAME, ADDRESS, TELEPHONE & HEALTH FIRST COLORADO ID Health First Colorado ID #		SUPPLIER NAME, ADDRESS, TELEPHONE AND PROVIDER ID# Health First Colorado Provider ID #
PLACE OF SERVICE _____	HCPCS CODE	MEMBER DOB_____/_____/_____ Sex_(M/F)
NAME and ADDRESS of FACILITY if residing in a nursing facility	_____ _____ _____ _____	QUALIFIED PRACTITIONER NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (_____)_____-_____ UPIN or NPI #_____

SECTION B - Information in this section does not have to be completed by the Qualified Practitioner.

EST. LENGTH OF NEED (# OF MONTHS):_____1–99 *(99=LIFETIME)*	DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1 – 8. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)____/____/____	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
	2.
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
Y N D	4. If you are ordering portable oxygen, is the member mobile within the residence or their mobile community? If you are not ordering portable oxygen, circle D.
_____LPM	5. Enter the highest oxygen flow rate ordered for this member in liters per minute. If less than 1 LPM, enter a "X".
a)_____mm Hg b)_____% c) ___/____/_____	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with member in a chronic stable state. Enter date of test (c).

ANSWERS	ANSWER QUESTIONS 7 - 9 ONLY IF PO2 = 56 – 59 OR OXYGEN SATURATION = 89 IN QUESTION 1
Y N	7. Does the member have dependent edema due to congestive heart failure?
Y N	8. Does the member 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 N	9. Does the member have a hematocrit greater than 56%?

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SECTION C - Narrative Description of Equipment and Cost
Narrative description of all items, accessories and options ordered

SECTION D - Qualified Licensed Practitioner Attestation and Signature/Date
I certify that I am the qualified licensed practitioner who is responsible for the care of the member 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 that section may subject me to civil or criminal liability. QUALIFIED LICENSED PRACTITIONER_____DATE____/____/____ **Signature and Date Stamps Are Not Acceptable.**
***RETAIN IN MEMBER'S FILE**

Revised September 2021