Reset Form

Ohio Department of Medicaid

Certificate of Medical Necessity/Prescription
Pulse Oximeter

SECTION A: Consumer/Provider Information

Certification Type:	☐ **Initial**	☐ **Revised**	☐ **Recertification**
Consumer Name:		Provider's Name:	
Consumer DOB:	Consumer Sex: ☐ Female ☐ Male	Consumer HT (in.):	Consumer WT (lbs.):
(If consumer is not residing at home address) Facility Name:		Prescriber's Name:	
		Prescriber's NPI Number:	
Facility Address:		Prescriber's Telephone:	
Facility City, State and Zip Code:		Prescriber's Medicaid Legacy Number:	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months): 1-99 (99=**LIFETIME**)	Diagnosis Codes (ICD-9) and Descriptions:
Last Consumer Medical Examination (MM/DD/YR):	

ANSWERS	ANSWER QUESTIONS 1-6. (Check **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
☐ Y ☐ N ☐ D	1. Does the consumer have a documented serious respiratory diagnosis, which requires short-term oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen?
☐ Y ☐ N ☐ D	2. Is the consumer dependent on a ventilator with supplemental oxygen?
☐ Y ☐ N ☐ D	3. Does the consumer have a tracheostomy and dependent on supplemental oxygen?
☐ Y ☐ N ☐ D	4. Does the consumer require supplemental oxygen and has unstable saturations?
☐ Y ☐ N ☐ D	5. Is the beneficiary being weaned off of supplemental oxygen?
☐ Y ☐ N ☐ D	6. Does the consumer require monitoring during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which the prescriber needs documentation of the consumer's blood oxygen saturation?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):
NAME: TITLE: EMPLOYER:

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for each item, accessory, and option.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature:	Date: