Certificate of Medical Necessity

Form for oxygen – This CMN is not required with the claim. It is completed by the ordering physician and maintained in file by the oxygen provider.

BlueCross BlueShield of Kansas

Section 1A – Patient Information

CLEAR DATA

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Date of Birth | Height | Weight

Section 1B – Supplier Information

Supplier Name | Address

Phone Number | NPI Number | City

State | ZIP Code | +4 | County

Section 1C – Physician Information

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Section 2 – Medical Necessity Information

Note: Physician, if this section is blank, please complete.

Initial Certification Date | Revised Certification Date

Estimated length of need (number of months) _____
1 – 99 (99 = Lifetime)

Enter the result of the most recent test taken ON or BEFORE the certification date listed above:

Arterial blood gas PO/2: _____% (60 PO/2)

Oxygen saturation test: _____% (89% or below)

Date of test: _____ _____ _____

Covered diagnoses for stationary and portable:

- ☐ Bronchiolectasis
- ☐ Cancer
- ☐ CHF
- ☐ COPD
- ☐ Chronic bronchitis
- ☐ Chronic interstitial pneumonia
- ☐ Cystic fibrosis
- ☐ Emphysema
- ☐ Hypoxemia
- ☐ Pulmonary hypertension
- ☐ Pulmonary fibrosis
- ☐ Secondary polycythemia
- ☐ Sleep apnea
- ☐ Other

Please continue on the next page.

Section 2 – Medical Necessity Information (continued)

☐ Lab report attached

☐ Results can be confirmed by _____

Related to the question directly above, check the appropriate box below:

☐ During normal activities of daily living (walking, sitting)

☐ During exercise therapy

☐ Other

Stationary oxygen flow rate presribed:

_____ LPM _____ hours per day

Portable oxygen flow rate presribed:
(if different than stationary flow rate prescribed)

_____ LPM _____ hours per day

If ordering portable oxygen:

☐ The patient is mobile beyond 50 feet of stationary system

☐ I have prescribed an exercise therapy program

☐ The patient suffers from cluster or migraine headaches

☐ Other _____

Section 3 – Narrative Description of Equipment

Check narrative description of the equipment you are ordering:

☐ Liquid stationary

☐ Conserving device

☐ Concentrator

☐ Gaseous portable

☐ Liquid portable

Section 4 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

_____ Physician's Signature (Signature and date stamps are not acceptable)

_____ _____ _____ Date Signed

Do not submit with claim. Please retain in patient file for possible review in the future.