DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0534

DME 484.3

CERTIFICATE OF MEDICAL NECESSITY
CMS-484— OXYGEN

PATIENT NAME, ADDRESS, TELEPHONE and HICN Testing Patient () - HCN	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #

NAME and ADDRESS of FACILITY if applicable (see reverse) ,		PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # , () - UPIN or NPI #

EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99=LIFETIME)	DIAGNOSIS CODES:

ANSWERS	ANSWER QUESTIONS 1-9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a) 99 mm Hg b) 100 % 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.
☐ 1 ☐ 2 ☐ 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
☐ 1 ☐ 2 ☐ 3	3. Check 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 patient mobile within the home? If you are not ordering portable oxygen, check D.
1 LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM,enter an "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 patient in a chronic stable state. Enter date of test (c).

ANSWER QUESTIONS 79 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1

☐ Y ☐ N	7. Does the patient have dependent edema due to congestive heart failure?
☐ Y ☐ N	8. Does the patient 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 patient have a hematocrit greater than 56%?

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

NAME TITLE EMPLOYER

(1) Narrative description of all items, accessories and option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)

I certify that I am the treating physician 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.

PHYSICIAN'S SIGNATURE

DATE **Electronically Signed by: , MD 2015-07-23 18:29:24 -0500**

Signature and Date Stamps Are Not Acceptable.