Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: PULSE OXIMETERS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	

*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.

Applicable specifications — HCPCS code, description, make, model, serial number, accessories, etc.

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation	Prior PA number

☐ Rental of oximeter for _____ days (≤ 90), from ___/___/_____ to ___/___/_____
☐ Purchase of oximeter
☐ Payment for probes, supplies, and accessories (≤ 12 months)

Diagnostic monitoring

- ☐ This individual was currently being weaned or was about to be weaned from an oxygen supply.
- ☐ This individual was oxygen-dependent and was in a clinically unstable condition.

☐ Attached are previously recorded oximeter data.
Assessment:

Continuous monitoring

- ☐ This individual exhibits clinical instability (evidenced by chronically compromised respiration and frequently varying oxygen requirements).
- ☐ This individual is at risk for critical fluctuations in oxygen saturation (e.g., hyperoxia, hypoxia).

At least one of the following conditions is present:

- ☐ Frequent bradycardia
- ☐ Frequent oxygen desaturation
- ☐ Chronic lung disease
- ☐ Ventilator-dependency
- ☐ Poor growth and development suggesting inadequate oxygenation
- ☐ Another specific risk factor: _____

☐ The following documentation is attached: _____

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.