Medicaid Certificate of Medical Necessity for CPAP/BIPAP or Oxygen Therapy Form

SECTION A - (To Be Completed By Physician or Physician’s Staff)

<table>
<thead>
<tr>
<th>Client Name: __________________________</th>
<th>Client Medicaid # __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name: ______________________</td>
<td>Physician Medicaid # ______________________</td>
</tr>
<tr>
<td></td>
<td>Physician License # ______________________</td>
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<td></td>
<td>Physician Phone # __________________________</td>
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<tr>
<td>Supplier Name ____________________________________________________________________________</td>
<td></td>
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<tr>
<td>Address: ________________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Contact Person: ________________________</td>
<td>Medicaid TPI Number: ______________________</td>
</tr>
<tr>
<td>Phone Number: _________________________</td>
<td>Fax Number: _______________________________</td>
</tr>
</tbody>
</table>

SECTION B - (To Be Completed By Physician)

CPAP/BIPAP S REQUEST:

Diagnosis: ____________________________________________________________

Date of Polysomnogram: (Polysomnogram required for all CPAP requests)

If request is for BIPAP, explanation of the inability to tolerate CPAP:

AHI/RDI: __________________ Sleep Time: _____________ hrs  Total Apneas: _____________

Obstructive apneas: __________________________  Lowest Oxygen Saturation: ________%

BIPAP ST REQUEST:

Diagnosis: ____________________________________________________________

If request is for BIPAP ST, explanation of the inability to tolerate BIPAP S:

Date of Polysomnogram: (If Applicable)

Lowest Oxygen Saturation: ________% OR Arterial PO2: __________ mm Hg

If prescribed for central sleep apnea: Central apneas/hr: __________ Longest central apnea: ________ sec.

OXYGEN THERAPY REQUEST:

Diagnosis: ____________________________________________________________

Lowest Oxygen Saturation at rest or with exercise : ________% OR Arterial PO2: __________ mm Hg

Lowest Oxygen Saturation during sleep: ________% OR Arterial PO2: __________ mm Hg

Flow rate: ________/min  Hours of treatment per day: ___________________ (estimated)

Is oxygen therapy required for mobility within the home?  Yes: ______  No: ________

Is oxygen therapy required for mobility when leaving the home?  Yes: ______  No: ________

Prescribing Physician-Signature: __________________________ Date: __________

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form