FAX: 855-475-5614 PHONE: 833-523-2609

Prior Authorization Respiratory Devices Request Form

onehome

Date Requested: **Certification Date:** ☐ **Initial** ☐ **Revised** ☐**Recertification**

☐ Standard Request	☐ Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. **Provider signature:** ___________________Date: __________
Patient Name:	Ordering Provider:
Patient Health Insurance ID #	Face to Face Visit Date (within 30 days prior to initial Certification):
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: Fax:
Height: ____ Feet _____ Inches Weight: ____ Lbs. **Length of time needed(#Months)**: _________ **Oxygen/Portable Oxygen Concentrator**: Oxygen Flow: ☐Continuous ☐Pulse Oxygen Route: _________ Hours of Use: __________ **Apnea Monitor**: Heart Rate High__________ Heart Rate Low______ Apnea Delay: _________ **Pediatric Oximeter**: Heart rate: High________ Low_______	☐Oxygen Concentrator HCPCS: __________ ☐Portable Oxygen Concentrator HCPCS: _________ ☐Apnea Monitor HCPCS: ________ ☐Pediatric Oximeter HCPCS: _______ ☐Supplies HCPCS: ________ HCPCS: _______ HCPCS: _______ HCPCS: _________ HCPCS: _______ HCPCS: _______
Oxygen/Portable Oxygen Concentrator Medical Necessity Criteria (Group I Criteria-Recertification-12 months after initial certification)	
1.) Enter the results of recent test taken on or before the certification date listed above. A.) Arterial blood gas PO2 and/or B.) oxygen saturation test. C.) Date of test (most recent study obtained within 30 days prior to date of initial Certification).	**A**: ________ **mmHg** **B:** _________**%** **C:** ___/_____/_______
2.) Was the test in Question 1 performed? A.) with the patient in a chronic stable state as an outpatient B.) within 2 days prior to discharge from inpatient facility to home, OR C.) under other circumstances?	☐**A** ☐**B** ☐**C**
3.) Check the one letter for the condition of the test in Q 1: A.) at rest; B.) during exercise; C.) during sleep	☐**A** ☐**B** ☐**C**
4.) If you are ordering portable oxygen, is patient mobile within the home and a qualifying blood gas study performed while awake?	☐**Y** ☐**N** ☐**N/A** **Qualifying Sat: awake(at rest)_______During Exercise:** _________
5.) Enter the highest oxygen flow rate ordered for this patient in liters per minute.	________ **LPM**
6.) If greater than 4 LPM is prescribed, enter results of 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. C.) enter date of test	**A**: ______ **mmHg** **B:** _______**%** **C:** ___/_____/_______
Answer Questions 7-9 only if PO2 = 56-59 or oxygen saturation =89 in Question 1 (Group II Criteria-Recertification- 3 months after initial certification)	
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%?	☐**Y** ☐**N**
Please fax/email completed form along with Supporting Clinical Documentation to include Physician Order and Letter of Medical Necessity. Please note: Prescription is valid for one year from signature date unless order changes.	

Physician Signature: ______________________________ Date_____________