

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

Section A - (To Be Completed By Physician or Physician's Staff)			
Client Name:		Client Medicaid Number:	
Physician Information			
Name:		Telephone:	
Address:			
License Number:	TPI:	NPI:	
Supplier Information			
Name:		Contact Person:	
Address:			
Telephone:		Fax number:	
TPI:		NPI:	
Taxonomy:		Benefit Code:	
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 (hours):	Total Apneas:	
Obstructive apneas:	Lowest Oxygen Saturation (percent):		
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 (percent):		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 (percent):		or     Arterial PO2 (mm Hg):	
Lowest Oxygen Saturation during sleep (percent):		or     Arterial PO2 (mm Hg):	
Flow rate (l/min.):	Hours of treatment per day (estimated):		
Is oxygen therapy required for mobility within the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is oxygen therapy required for mobility when leaving the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescribing Physician Signature:			Date:     /     /
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form			