

Sample

# ArmsCare Inc.

Hospital Equipment and Services in Your Home  
1-888-545-4949 or 724-545-3200

## Home Oxygen/Respiratory Fax to: 724-543-2718

### Referral Information:

Date 4/10/08 Time 3:33pm  
Facility Armscare Facility Contact Person: Patty Peppermint  
Facility Address: One Dote Drive Bldg. 400  
Hittington PA 11620 RM#: 430  
Phone# 724-545-3200 Fax# 724-543-2718

### Patient Information:

Patient Name John Doe SSN#: 000-00-0000  
Diagnosis J99.02 D.O.B. 01/01/08 Phone: 724-555-0000  
Address 110 Anywhere Street  
Anytown PA 12345  
Emergency Contact Jane Doe Emergency Phone 724-555-0000  
Special Instructions/Education \_\_\_\_\_

### Insurance Information:

Primary Insurance Security Blue  
ID# S01000000000 Group # 000000  
Secondary Insurance Medicare  
ID# 000000000A Group # \_\_\_\_\_

<b>Prescription:</b> Oxygen (Please fax O2 Sats/ABGs) <input checked="" type="checkbox"/> Concentrator <input type="checkbox"/> Liquid <input type="checkbox"/> Portable <input type="checkbox"/> Gaseous <input type="checkbox"/> Other _____		Test Results: Test Date <u>4/10/08</u> <input type="checkbox"/> Rest <input type="checkbox"/> Exercise <input type="checkbox"/> Nocturnal <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen @ <u>2</u> lpm SpO2 <u>85</u> % or PaO2 _____ <input type="checkbox"/> RDI _____ <input type="checkbox"/> Low sat _____	
Use Oxygen at _____ liters/minute		Hours per day _____ <input type="checkbox"/> Mask <input type="checkbox"/> Nasal Cannula	
<b>Sleep Equipment (please fax sleep study)</b> <input type="checkbox"/> CPAP @ _____ cmH20 <input type="checkbox"/> BiPAP @ _____ IPAP _____ EPAP _____ _____ Back-up Rate (BIPAP S/T) <input type="checkbox"/> Humidifier _____ Cool _____ Heated <input type="checkbox"/> Oxygen Bled in @ _____ LPM <input type="checkbox"/> Mask, size if available _____		<b>Other HME Equipment</b> <input type="checkbox"/> Nebulizer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other _____	
Physician Name: <u>Dr. Wright</u> Address: <u>110 Anywhere Street</u> <u>Anytown PA 12345</u>		Phone: <u>724-555-1234</u> Fax: <u>724-555-1123</u>	
Physician NPI # <u>000000000</u>			

Sample

## CERTIFICATE OF MEDICAL NECESSITY CMS-484 — OXYGEN

<b>SECTION A</b> Certification Type/Date: INITIAL <u>4/10/08</u> REVISED <u>  /  /  </u> RECERTIFICATION <u>  /  /  </u>		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER John Doe 16 Anywhere Street Anytown PA 12345 (724) 000-0000 HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER Armscare One Date Drive Bldg 400 Ste. 430 Pittsburg PA 15201 (724) 545-3200 NSC or NPI # _____
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB <u>01/01/01</u> Sex <u>M</u> (M/F)
NAME and ADDRESS of FACILITY <i>if applicable (see reverse)</i> ABC Nursing Home 2 Anywhere Street Anytown PA 12345		PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN Dr. Wright 1 Anywhere Street Anytown PA 12345 (724) 555-1234 UPIN or NPI # <u>000000000</u>
<b>SECTION B</b> Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): <u>99</u> 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): <u>428.0</u> _____
ANSWERS	ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)	
a) _____ mm Hg b) <u>95</u> % c) <u>4/10/08</u>	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 <input checked="" type="radio"/> 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?	
<input checked="" type="radio"/> 1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep	
<input checked="" type="radio"/> Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.	
<u>2</u> LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".	
a) _____ mm Hg b) _____ % c) <u>  /  /  </u>	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 7-9 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: _____		
<b>SECTION C</b> Narrative Description of Equipment and Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)		
<b>SECTION D</b> Physician Attestation and Signature/Date		
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 <u>[Signature]</u>		DATE <u>4/10/08</u>

Sample

# INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN (CMS-484)

<b>SECTION A:</b>	<b>(May be completed by the supplier)</b>
<b>CERTIFICATION TYPE/DATE:</b>	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
<b>PATIENT INFORMATION:</b>	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HCN) as it appears on his/her Medicare card and on the claim form.
<b>SUPPLIER INFORMATION:</b>	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)
<b>PLACE OF SERVICE:</b>	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
<b>FACILITY NAME:</b>	If the place of service is a facility, indicate the name and complete address of the facility.
<b>HCPCS CODES:</b>	List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.
<b>PATIENT DOB, HEIGHT, WEIGHT AND SEX:</b>	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
<b>PHYSICIAN NAME, ADDRESS:</b>	Indicate the PHYSICIAN'S name and complete mailing address.
<b>PHYSICIAN INFORMATION:</b>	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
<b>PHYSICIAN'S TELEPHONE NO:</b>	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
<b>SECTION B:</b>	<b>(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)</b>
<b>EST. LENGTH OF NEED:</b>	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".
<b>DIAGNOSIS CODES:</b>	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).
<b>QUESTION SECTION:</b>	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.
<b>NAME OF PERSON ANSWERING SECTION B QUESTIONS:</b>	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
<b>SECTION C:</b>	<b>(To be completed by the supplier)</b>
<b>NARRATIVE DESCRIPTION OF EQUIPMENT &amp; COST:</b>	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.
<b>SECTION D:</b>	<b>(To be completed by the physician)</b>
<b>PHYSICIAN ATTESTATION:</b>	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
<b>PHYSICIAN SIGNATURE AND DATE:</b>	After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0534. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd, Baltimore, Maryland 21244.

**DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.**