Oxygen Equipment and Supplies

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

Oxygen DME prior authorizations may be expedited if the recipient is discharging from a hospital and the equipment is an emergency need. Please see the Medicaid Services Manual (MSM) Chapter 1300 Section 1303. If your request meets this criteria, please call the Prior Authorization Customer Service unit at (800) 525-2395 and notify a representative of the need to expedite a PA. Information you will be required to present: 1. PA number, 2. Rationale for need to expedite.

Policy requirements are referenced from MSM Chapter 1300, Appendix B, at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

DATE OF REQUEST: ______ /______ /_________

REQUIRED FOR RETROSPECTIVE REQUESTS ONLY
This recipient was determined eligible for Medicaid benefits on: ______ /______ /_________

NOTES:

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:	Phone:	DOB:
Address:		
City:	State:	Zip Code:

INSURANCE INFORMATION
Medicare: ☐ Part A ☐ Part B ID#: ____________________ Other Insurance: ________________________
Additional Comments:____

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:	Phone:	Fax:

SERVICING PROVIDER INFORMATION

Servicing Provider Name:		
NPI:	Phone:	Fax:
Address:		
City:	State:	Zip Code:
Contact Name:		

REQUEST

Diagnosis Code/ICD:

REQUEST TYPE: ☐ Initial ☐ Continued Services ☐ Retrospective ☐ Unscheduled Revision

TESTS AND DOCUMENTATION

Date of 02 saturation:_________________ *(O2 sats must be performed within 60 days of the requested date of service. O2 sats will not be accepted from an oxygen supplier.)*

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Oximetry test result:_______________________________ *(Oximetry test must be performed by a physician or qualified laboratory)*

Source of oxygen saturation: *(check one)* ☐ Arterial blood gases ☐ Oximetry

Conditions of Study (required): *(check all that apply)*

☐ Rest ☐ Sleeping ☐ Exercising ☐ Room Air ☐ On Oxygen

☐ Other: (please specify) ____

Documentation: *(The following items are required to process this request. Please check the boxes to indicate they are attached.)*

☐ Physician's order (or ☐ PA form is signed by the Ordering Physician)

☐ A copy of the current, valid, signed and dated prescription within the last 6 months

☐ Face-to-face relevant to the equipment/supplies requested within the last 6 months

☐ O2 Saturation Results enclosed

☐ Medical Necessity Documentation enclosed

In the table below, use column 1 to enter the HCPCS code. Check column 2 if no HCPCS code is assigned from PDAC for the item being requested. Use column 3 to enter a description of the item. Enter the appropriate modifier and number of requested units in columns 4 and 5. In column 6, enter "R" if the equipment is for rent and "P" if the equipment is for purchase. If the item is covered by Medicare, enter a "Y" in column 7. If the item is not covered by Medicare, enter an "N" in column 7. Enter the requested "Start" and "End" dates for each item in columns 8 and 9.

1	2	3	4	5	6	7	8	9
HCPCS CODE	No HCPCS code	DESCRIPTION	MODIFIER	UNITS	R or P	MEDICARE Y or N	START DATE	END DATE

PROVIDER CERTIFICATION (*Ordering provider signature and date required or Physician's Order.*)

I hereby certify that this treatment is necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Ordering physician's signature: Date:

Printed Name and Title:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.