VERIO HEALTHCARE

Certificate of Medical Necessity – Oxygen

Member Name: _____ DOB: ____/_____/_____

Address: _____ CIN: _____

City: _____ Ca. Zip: _____ _____

PH: _(_____)_____-_____

Equipment Prescribed:

____ Oxygen Concentrator (E1390) ____ Portable Oxygen E tank (E0431)

____ Oxygen Humidifier ____ Portable Oxygen Conserving Unit M (E0431) (on demand flow)

____ Other: _____

Liter flow @ _____ liters per minute **Delivery Method**: ___ nasal cannula ___ mask other: _____

Frequency: ___ Continuous ___ PRN ___ with activity

Diagnosis(s) (ICD-10): _____

Length of need (# of months): _____

Notes: _____

_____

_____ _____/_____/_____

MD Signature Date

MD Name: _____ NPI: _____

Phone #: _____