

Review Request for Home Oxygen Therapy

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 8/28/08	Policy Effective Date: 02/26/09	Provider Tool Effective Date: 02/26/09
----------------------------------	---------------------------------	--

Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:
Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	
Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient
Service Requested (CPT if known):	<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for long-term use of home oxygen therapy
- Request is for short-term use of home oxygen therapy
- Request is for supplemental oxygen during exercise only
- Request is for nocturnal supplemental oxygen
- Request is for the use of preset regulators used with portable oxygen systems
- Adult member has arterial partial pressure of oxygen (PaO₂) less than or equal to 55mmHg or arterial oxygen saturation (SaO₂) less than or equal to 88%
- Adult member has PaO₂ levels between 56 and 59 or SaO₂ less than or equal to 89% (check all that apply):
 - Member has pulmonary hypertension
 - Member has cor pulmonale
 - Member has edema secondary to right heart failure
 - Member has erythrocytosis with hematocrit greater than 55%
 - Other: _____
- Adult member desaturates to a SaO₂ less than or equal to 88% only during exercise and who demonstrates improvement in both hypoxia and dyspnea or exercise capacity when using supplemental oxygen.

www.BlueChoiceSCMedicaid.com

- Adult member desaturates to a SaO2 less than or equal to 88% only during sleep (check all that apply)
 - Desaturation is for more than 30% of the night
 - There is evidence of otherwise unexplained pulmonary hypertension
 - There is evidence of otherwise unexplained cor pulmonale
 - There is evidence of otherwise unexplained edema secondary to right heart failure
 - There is evidence of otherwise unexplained erythrocytosis with hematocrit greater than 55%
 - Other: _____
- Adult member has had obstructive sleep apnea (OSA) and other nocturnal apnea or hypoventilation syndromes ruled out
- Adult member has OSA or other nocturnal apnea or hypoventilation syndromes and persistent desaturation continues despite correction by continuous positive airway pressure (CPAP) or non-invasive positive pressure respiratory assist devices (BiPAP)
- Infant or child with a arterial partial pressure of oxygen (PaO2) less than or equal to 60 mm Hg or arterial oxygen saturation (SaO2) less than or equal to 92%.
- Member with chronic hypoxia (check all that apply)
 - Member has diffuse interstitial lung disease
 - Member has chronic obstructive pulmonary disease
 - Member has bronchiectasis
 - Member has widespread pulmonary neoplasm
 - Member has pediatric bronchopulmonary dysplasia (BPD)
 - Member has pulmonary hypertension
 - Member has cystic fibrosis
 - Member has recurring congestive heart failure due to chronic cor pulmonale
 - Other: _____
- Member with acute hypoxia (check all that apply)
 - Member has pneumonia
 - Member has bronchiolitis
 - Member has exacerbation of chronic obstructive pulmonary disease
 - Other: _____
- Member with a diagnosis unrelated to hypoxia (check all that apply)
 - Member has cluster headaches
 - Other: _____
- Member with severe peripheral vascular disease with clinically evident desaturation in one or more extremities in the absence of hypoxia
- Member with terminal illness not affecting the respiratory system
- Member with angina pectoris or dyspnea in the absence of documented associated cor pulmonale or hypoxia

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**