

Alabama Medicaid Agency
Oxygen Therapy
Request for Prior Authorization and Prescription

Patient Information

Patient Name _____ Patient Medicaid Number _____
Date of Birth _____ Diagnosis _____

Prescription Information

Date last seen by physician _____
Date oxygen prescribed _____ Initial Renewal
Liters per minute _____ Hours per day _____
Method of delivery (nasal cannula, mask, etc.) _____
If portable oxygen prescribed, state purpose _____
Estimated length of time oxygen needed _____ (months)
Describe type, duration, and frequency of recipient's daily activities outside the home

Equipment Prescribed

- Stationary System
 Compressed Gas
 Oxygen Concentrator
- Portable System
 Compressed Gas

Laboratory Results

ABG (P02) result _____ Room Air Oxygen Date of test _____
Oxygen Saturation _____ Room Air Oxygen Date of test _____

Must attach a copy of the ABG report or oxygen saturation readout. ABG not required for children.

If ABG was not performed, please explain _____

If test not performed on room air, please explain _____

If ABG exceeds 59 mm Hg or if oxygen saturation exceeds 89 percent (94 percent for children three and under), physician must justify need for oxygen with more medical information.

(Attach a separate letter if more space is needed to justify medical necessity)

I certify that oxygen is medically necessary.

Physician Signature _____ Date _____
(Stamped signatures are not acceptable)