BlueCross BlueShield of Florida

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DURABLE MEDICAL EQUIPMENT CERTIFICATION

BIRMINGHAM SERVICE CENTER • P.O. Box 10527 • Birmingham, AL 35201-0500

Fax: 1-205-220-9560

Check As Appropriate: ☐ DME ☐ OXYGEN ☐ IPPB ☐ GLUCOMETER ☐ CPAP ☐ BIPAP | ☐ CERTIFICATION ☐ RECERTIFICATION

PATIENT INFORMATION — COMPLETE ALL ITEMS PERTAINING TO THE PATIENT'S CONDITION AND EQUIPMENT

1. Patient's Name

2. Date Patient Last Seen by Doctor

3. Subscriber Number

4. Diagnosis

5. Prognosis
☐ Good ☐ Fair ☐ Poor

6. Estimated Number of Months Equipment Needed

_____

(Do NOT put "INDEFINITE"; be specific)

Date Prescribed _____

8. Rental Period This Certification Applies To
(Certification Length CANNOT Exceed 12 Months)

First Day (MM-DD-YYYY)	Last Day (MM-DD-YYYY)
__/__/____	__/__/____

9. Supplier's Name, Street Address, City, State, ZIP Code, Phone

10. Supplier's Provider Number

7. What Is The Patient's Condition Concerning Mobility

a. Bed Confined? ☐ No ☐ Yes - Complete immediately below
- ☐ 50% of the Time
- ☐ 75% of the Time
- ☐ 100% of the Time

b. Room Confined? ☐ No ☐ Yes

c. Wheelchair Confined? ☐ No ☐ Yes

d. Ambulatory? ☐ No ☐ Yes - Complete immediately below
- ☐ Assistance Not Required
- ☐ Assisted by Walker or Cane
- ☐ Assisted by Person

e. Is Patient Disoriented? ☐ No ☐ Yes

11. Requested HCPCS code(s)

GENERAL EQUIPMENT — SEE THE SECTIONS ON THE BACK OF THE FORM FOR OXYGEN AND IPPB

12. General Equipment Selected for Patient

- ☐ a. Alternating P.P. & Pump *(Complete #15)*
- ☐ b. Bed, Electric *(Complete #13 and #14)*
- ☐ c. Bed, Semi-electric *(Complete #13 and #14)*
- ☐ d. Bed, Standard
- ☐ e Bed, Variable Height *(Complete #14)*
- ☐ f. Cane or Quad Cane
- ☐ g. Walker ☐ With Wheels
- ☐ h. Wheelchair
  - ☐ 1) Standard
  - ☐ 2) Electric
  - ☐ 3) Detachable Arms
  - ☐ 4) Leg Rests
  - ☐ 5) Special; Type:_____
- ☐ i. Commode, Bedside
- ☐ j. Lift, Patient
- ☐ k. Nebulizer, Hand-held
- ☐ l. Nebulizer, Ultrasonic
- ☐ m. Percussor *(Complete #16)*
- ☐ n. Rails, Bedside
- ☐ o. Suction Machine
- ☐ p. Sitz Bath
- ☐ q. Traction Equipment
- ☐ r. Trapeze Bar
- ☐ s. Other *(Describe)* _____

_____

COMPLETE WHEN INDICATED IN QUESTION 12

13. Regarding Electric Beds, is the Patient able to work the controls and cause the adjustments? ☐ Yes ☐ No

14. Does the Patient's condition require frequent changes in body position not feasible in an ordinary bed?
☐ No ☐ Yes; condition is:

15. Does the Patient now have, or is the Patient susceptible to, decubitus ulcers? ☐ Yes ☐ No

16. a. Has the Patient been trained by a Therapist or Physician to use a powered percussor? ☐ Yes ☐ No

b. Is there anyone else at the Patient's home who could administer manual therapy? ☐ Yes ☐ No

17. CPAP/BIPAP

Date of sleep study:_____

Name of facility:_____

Respiratory disturbance index

(RDI) preCPAP:_____

☐ CPAP pressures:_____

☐ BIPAP pressures:_____

18. If for recertification, has Patient demonstrated compliance in the use of this equipment? ☐ Yes ☐ No

SEE REVERSE SIDE FOR SIGNATURE

OXYGEN

You must provide the lab results of the blood gas study (PaO_2 or oximetry) which you retain in your files. NOTE: You must also notify the carrier in writing when a patient's condition or oxygen needs change.

19. Report Date	PaO_2 Level (MM of Hg)	Oximetry Level (MM of Hg)	Where Was Test Done? ☐ Patient's Home ☐ Doctor's Office ☐ Nursing Home ☐ Independent Lab ☐ Hospital ☐ ASC	Check Condition of Patient During PaO_2 or Oximetry Level Test ☐ During Activities, Such as Exercise ☐ At Rest ☐ While Sleeping	Was Patient on Room Air or Oxygen at Time of Blood Gas Study? ☐ Room Air ☐ Oxygen

20. a. Type Oxygen Unit Prescribed: ☐ Portable ☐ Stationary ☐ Concentrator b. Type Oxygen Unit Prescribed: ☐ Liquid ☐ Gaseous

21. How many hours per day is the Patient on Oxygen? a. Non-portable O_2: _____ hours b. Portable O_2: _____ hours
☐ For exercise therapy outside the home: _____ hours at a time to be repeated _____

22. How many hours per day is the Patient on Oxygen? a. Non-portable O_2: _____ hours b. Portable O_2: _____ hours
c. What is the flow rate in liters of O_2 per minute? _____ d. Delivery methods? ☐ Nasal Cannula ☐ Mask

23. The following treatments were tried WITHOUT SUCCESS for this Patient PRIOR TO OXYGEN THERAPY:

		TREATMENT DATES: BEGIN (MM-DD-YYYY)	ENDED (MM-DD-YYYY)
☐ YES ☐ NO Bronchodilators:			
☐ YES ☐ NO Medications:	MEDICATION NAME / DOSAGE		
☐ YES ☐ NO Physical Therapy:	☐ a. Percussors ☐ b. Breathing Exercises		
☐ YES ☐ NO Other Treatment:			

GENERAL EQUIPMENT

CERTIFICATION LENGTH CANNOT EXCEED SIX MONTHS

24. Current results of any pulmonary function studies are:
Forced vital capacity before and after aerosol bronchodilators:

Before	After	Predicted V.C.	Date of Studies

25. What is the IPPB frequency of use?

26. IPPB used to *(Check all that apply):*
- ☐ a. Deliver aerosolized medications
- ☐ b. Facilitate clearance of secretions
- ☐ c. Produce mechanical dilation of the bronchi and lungs
- ☐ d. Correct or prevent atelectasis
- ☐ e. Counteract pulmonary congestion or edema
- ☐ f. Decrease the work of breathing
- ☐ g. Regulate inspiratory and expiratory flow patterns
- ☐ h. Other *(Explain)*: _____

27. Can the Patient successfully use a hand-held nebulizer or a nebulizer with a compressor? ☐ YES ☐ NO *(Explain)*

GLUCOMETER

28. Is this Patient an insulin-dependent diabetic? ☐ YES ☐ NO

29. What is the average daily dose of insulin? _____ Units

30. What type of insulin is being used? ☐ Regular ☐ NPH
☐ Other *(Describe):* _____

31. What is the number of daily insulin injections?

32. Does the Patient have widely fluctuating blood sugars before meal time? ☐ YES ☐ NO

33. Does the Patient have frequent episodes of insulin reactions? ☐ YES ☐ NO

34. a. Is it necessary for the Patient to make frequent checks of his or her blood glucose level? ☐ YES ☐ NO
b. Is the Patient's Vision impaired enough to require a special glucose monitoring system at home? ☐ YES ☐ NO
c. Is this Patient capable of being trained to use a home blood glucose monitor? ☐ YES ☐ NO

PHYSICIAN'S INFORMATION, CERTIFICATION OR RECERTIFICATION

NOTICE: This form must be completed, signed and dated by the prescribing physician to accurately adjudicate the DME Claim. Any misrepresentation or falsification of information herein may constitute fraud and be subject to legal action.

34. a. Physician's Name, Street Address, City, State, ZIP Code

b. Physician's Provider Number: _____

c. Physician's Specialty: _____

d. Office Telephone Number: _____

35. I certify that I am actively treating this patient, the equipment prescribed is part of my present course of treatment and is "reasonable and necessary," and is not prescribed as convenience equipment, plus all items completed on this form are accurate.

_____ _____
Attending Physician's Handwritten Signature (STAMPED signature is NOT Acceptable) Date