



**DURABLE MEDICAL EQUIPMENT**

Blue Cross and Blue Shield of Alabama • P.O. Box 362025  
Birmingham, Alabama 35236-2025 Fax: (205) 989-3899

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 <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
6. Estimated Number of Months Equipment Needed  <i>(Do NOT put "INDEFINITE"; be specific)</i>		7. What Is The Patient's Condition Concerning Mobility a. Bed Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes - Complete immediately below <input type="checkbox"/> 50% of the Time <input type="checkbox"/> 75% of the Time <input type="checkbox"/> 100% of the Time b. Room Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes c. Wheelchair Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes d. Ambulatory? <input type="checkbox"/> No <input type="checkbox"/> Yes - Complete immediately below <input type="checkbox"/> Assistance Not Required <input type="checkbox"/> Assisted by Walker or Cane <input type="checkbox"/> Assisted by Person e. Is Patient Disoriented? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Date Prescribed _____					
8. Rental Period This Certification Applies To <i>(Certification Length CANNOT Exceed 12 Months)</i>					
First Day (MM-DD-YYYY)	Last Day (MM-DD-YYYY)				
___/___/____	___/___/____				
9. Supplier's Name, Street Address, City, State, ZIP Code, Telephone #		11. Requested HCPCS code (s)			
10. Supplier's Provider Number					

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

12. General Equipment Selected for Patient		<b>COMPLETE WHEN INDICATED IN QUESTION 12</b>	
<input type="checkbox"/> a. Alternating P.P. & Pump <i>(Complete #15)</i> <input type="checkbox"/> b. Bed, Electric <i>(Complete #13 and #14)</i> <input type="checkbox"/> c. Bed, Semi-electric <i>(Complete #13 and #14)</i> <input type="checkbox"/> d. Bed, Standard <input type="checkbox"/> e. Bed, Variable Height <i>(Complete #14)</i> <input type="checkbox"/> f. Cane or Quad Cane <input type="checkbox"/> g. Walker <input type="checkbox"/> With Wheels <input type="checkbox"/> h. Wheelchair <input type="checkbox"/> 1) Standard <input type="checkbox"/> <input type="checkbox"/> 2) Electric <input type="checkbox"/> <input type="checkbox"/> 3) Detachable Arms <input type="checkbox"/> <input type="checkbox"/> 4) Leg Rests <input type="checkbox"/> <input type="checkbox"/> 5) Special; Type: _____ <input type="checkbox"/> i. Commode, Bedside <input type="checkbox"/> j. Lift, Patient <input type="checkbox"/> k. Nebulizer, Hand-held <input type="checkbox"/> l. Nebulizer, Ultrasonic <input type="checkbox"/> m. Percussor <i>(Complete #16)</i> <input type="checkbox"/> n. Rails, Bedside <input type="checkbox"/> o. Suction Machine <input type="checkbox"/> p. Sitz Bath <input type="checkbox"/> q. Traction Equipment <input type="checkbox"/> r. Trapeze Bar <input type="checkbox"/> s. Other <i>(Describe)</i> _____ _____		13. Regarding Electric Beds, is the Patient able to work the controls and cause the adjustments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		14. Does the Patient's condition require frequent changes in body position not feasible in an ordinary bed? <input type="checkbox"/> No <input type="checkbox"/> Yes; condition is:	
		15. Does the Patient now have or is the Patient susceptible to decubitus ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		16. a. Has the Patient been trained by a Therapist or Physician to use a powered percussor? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is there anyone else at the Patient's home who could administer manual therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		17. CPAP/BIPAP Date of sleep study: _____ Name of facility: _____ Respiratory disturbance index (RDI) preCPAP: _____ <input type="checkbox"/> CPAP pressures: _____ <input type="checkbox"/> BIPAP pressures: _____	
		18. If for recertification, has Patient demonstrated compliance in the use of this equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SEE REVERSE SIDE FOR SIGNATURE**

# OXYGEN

You Must Provide the Lab Results of the Blood Gas Study (PO<sub>2</sub> 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	PO <sub>2</sub> Level (MM of Hg)	Oximetry Level (MM of Hg)	Where Was Test Done? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Nursing Home <input type="checkbox"/> Independent Lab <input type="checkbox"/> Hospital <input type="checkbox"/> ASC	Check Condition of Patient During PO <sub>2</sub> or Oximetry Level Test <input type="checkbox"/> During Activities, Such as Exercise <input type="checkbox"/> At Rest <input type="checkbox"/> While Sleeping	Was Patient on Room Air or Oxygen at Time of Blood Gas Study? <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen
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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<sub>2</sub>: \_\_\_\_\_ hours      b. Portable O<sub>2</sub>: \_\_\_\_\_ 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<sub>2</sub>: \_\_\_\_\_ hours      b. Portable O<sub>2</sub>: \_\_\_\_\_ hours  
c. What is the flow rate in liters of O<sub>2</sub> 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)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bronchodilators:		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Medications:	MEDICATION NAME	DOSAGE
<input type="checkbox"/> YES <input type="checkbox"/> NO	Physical Therapy:	<input type="checkbox"/> a. Percussors <input type="checkbox"/> b. Breathing Exercises	
<input type="checkbox"/> YES <input type="checkbox"/> 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):

<input type="checkbox"/> a. Deliver aerosolized medications	<input type="checkbox"/> e. Counteract pulmonary congestion or edema
<input type="checkbox"/> b. Facilitate clearance of secretions	<input type="checkbox"/> f. Decrease the work of breathing
<input type="checkbox"/> c. Produce mechanical dilation of the bronchi and lungs	<input type="checkbox"/> g. Regulate inspiratory and expiratory flow patterns
<input type="checkbox"/> d. Correct or prevent atelectasis	<input type="checkbox"/> 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 to the items completed on this form are accurate.

Attending Physician's Handwritten Signature (STAMPED signature IS NOT Acceptable) \_\_\_\_\_ Date \_\_\_\_\_