Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593

PULSE OXIMETER REQUEST

Requested for: **Rental** ☐ **Purchase** ☐

For: **E0445**

Type of oximeter: _____

Beneficiary name: _____ Date of birth: ____/____/_____

Beneficiary Medicaid ID #: _____ KAN Be Healthy due: ____/____/_____

Provider contact name: _____ Phone number: _____

Provider Medicaid ID #: _____

Estimated length of need:_____ **Date service requested:** ___/___/____ - ___/___/____
From Through

Diagnosis: _____

☐ 1. Prescription must be kept on file by provider.

☐ 2. Letter of medical necessity from the physician which includes *diagnosis and pertinent medical history* which *justifies the need for the device requested.*

☐ 3. Written plan of care which documents **step-by-step** protocol to be used in case of desaturation. Copy must be sent with request: ☐ Copy home: ☐

☐ 4. Statement from physician, nurse, or case manager which verifies that the designated caregiver in the home is trained in above protocol. Caregiver must be capable of using device, documenting and maintaining record of results, and implementing appropriate interventions. Copy must be sent with request. ☐ _____

☐ 5. Primary diagnosis and medical history must justify use of the device.

☐ 6. Is beneficiary receiving oxygen? _____ Rate of O_2 administration: _____
Is use: Continuous ☐ Intermittent ☐ During seizures ☐

☐ 7. There is professional oversight (physician, home health nurse, case manager) of the plan of care or medical treatment plan.

☐ 8. Apnea monitor in the home and/or currently used by beneficiary? ☐

☐ 9. For **rental**, indicate if provider is willing to apply rent paid toward purchase price should long-term need be indicated after six months: _____.
Two probes per month considered COS with rental. Will additional probes be needed? _____
How many? _____ Price per probe: $_____ Procedure Code A4606

☐ 10. For **purchase**, supply: MSRP or provider's cost: $_____ Procedure Code A4606
Number of probes needed per month _____ and cost per probe $_____
☐ Warranty information
☐ Maintenance requirements
☐ Willing to apply past rental paid toward purchase price, and if so, how much? $_____

Provider Representative Signature:_____ **Date:** ___/___/_____

Fax completed forms to: 1-800-913-2229 or 785-274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.
Prior Authorization: 1-800-933-6593

Revised 10.2017