



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

DURABLE MEDICAL EQUIPMENT CERTIFICATION

P.O. Box 362025 • Birmingham, Alabama 35236-2025

Fax: (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 PORTIA BRONSON		2. Date Patient Last Seen by Doctor 04/18/2023	3. Subscriber Number 807697835
4. Diagnosis E11.65		5. Prognosis ☐ Good ☒ Fair ☐ Poor	
6. Estimated Number of Months Equipment Needed 60 <i>(Do NOT put "INDEFINITE"; be specific)</i>		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	
Date Prescribed 04/18/2023			
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)		
04/18/2023		04/18/2024	
9. Supplier's Name, Street Address, City, State, ZIP Code, Phone Sams Club Pharmacy 1080 Eastern Blvd Montgomery AL. 36117			
10. Supplier's Provider Number 111506		11. Requested HCPCS code(s) K0553	

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

12. General Equipment Selected for Patient		COMPLETE WHEN INDICATED IN QUESTION 12	
☐ a. Alternating P.P. & Pump <i>(Complete #15)</i> ☐ b. Bed, Electric <i>(Complete #13 and #14)</i> ☐ c. Bed, Semi-electric <i>(Complete #13 and #14)</i> ☐ d. Bed, Standard ☐ e. Bed, Variable Height <i>(Complete #14)</i> ☐ 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 <i>(Complete #16)</i> ☐ n. Rails, Bedside ☐ o. Suction Machine ☐ p. Sitz Bath ☐ q. Traction Equipment ☐ r. Trapeze Bar ☐ s. Other <i>(Describe)</i> _____		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 (PO₂ 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 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 PO 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:				25. What is the IPPB frequency of use?	
Before	After	Predicted V.C.	Date of Studies		
26. IPPB used to (Check all that apply):					
☐ a. Deliver aerosolized medications		☐ e. Counteract pulmonary congestion or edema			
☐ b. Facilitate clearance of secretions		☐ f. Decrease the work of breathing			
☐ c. Produce mechanical dilation of the bronchi and lungs		☐ g. Regulate inspiratory and expiratory flow patterns			
☐ d. Correct or prevent atelectasis		☐ 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? <u>0</u> Units	
30. What type of insulin is being used? ☐ Regular ☐ NPH ☒ Other (Describe): <u>N/A</u>		31. What is the number of daily insulin injections? <u>N/A</u>	
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 7461 EAST DR		c. Physician's Specialty: Family Nurse Practitioner	
b. Physician's Provider Number: <u>1215285879</u>		d. Office Telephone Number: <u>334-244-3281</u>	
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.			
LINDSEY BARTON, CRNP		4/20/2023	
Attending Physician's Handwritten Signature (STAMPED signature IS NOT Acceptable)		Date	