Traditional - Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies

Landmark Healthcare is unable to complete Section B of the attached Medicaid Oxygen form. Below is the equipment information that should be entered on the form in Section B for Oxygen Equipment.

Section B: Oxygen Therapy Request (Must be completed by physician)					
Type of request: ☑ Initial Request ☐ Renewal Request					
HCPCS Code	Description of DME Requested	Qty.	Price	Diagnosis	Brief Diagnosis Desciption
E1390	Oxygen Concentrator, rental	1	150.00		
E0431	Portable Oxygen, rental	1	75.00		
E0443	Portable Oxygen Contents	1	0.00		

Oxygen for COVID-19 patients is covered with (2) Diagnosis Codes:

1) U07.1 COVID-19

2) Associated Diagnosis (below reference is not all-inclusive):

- J12.81 Pneumonia due to SARS-associated coronavirus
- J20.8 Acute bronchitis due to other specified organisms
- J40 Bronchitis, not specified as acute or chronic
- J22 Unspecified acute lower respiratory infection
- J98.8 Other specified respiratory disorders
- J80 Acute respiratory distress syndrome (ARDS)
- R06.0 Dyspnea
- R05 Cough

Please contact our office with any questions – phone number: (817) 338-0007

Please FAX Patient Demographics, Completed Medicaid Oxygen Form, and Clinical Documentation to FAX# (817) 338-0816

Texas Medicaid Prior Authorization Request for Oxygen Therapy Devices and Supplies

Section A: Client and Provider Information (May be completed by provider)

Client Information

Client Name:	Medicaid Number:	Date of Birth:

Physician Information

Name:	Telephone:	Fax number:
License Number:	TPI:	NPI:

Supplier Information

Name: Landmark Healthcare Inc.	Telephone: 817-338-0007	Fax number: 817-338-0816
Address (Street, City, State, ZIP): 3515 NW Jim Wright Fwy Fort Worth TX 76106		
TPI: 287123801 / NPI: 1063575579	Taxonomy: 332BX2000	Benefit Code:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Supplier Representative's Printed Name:	
Supplier Representative's Signature:	Date Signed:

Section B: Oxygen Therapy Request (Must be completed by physician)

Type of request: ☑ Initial Request ☐ Renewal Request

HCPCS Code	Description of DME Requested	Qty.	Price	Diagnosis	Brief Diagnosis Desciption

***Note**: The "Duration of need for DME" and "Date client last seen last seen by physican," below **must** be filled in.*

Duration of need for DME: _____ month(s)	Date client last seen by physician:

Documentation of Medical Necessity

Date of testing:	Arterial pO_2 (mm HG):	Oxygen Saturation:

Lowest Oxygen Saturation at rest or with exercise (percent): or Arterial pO_2 (mm Hg):

Lowest Oxygen Saturation during sleep (percent): or Arterial pO_2 (mm Hg):

For pO_2 of 56-59 mm Hg or oxygen saturation 89% or higher (*for initial requests only*):

☐ Dependent edema ☐ Cor pulmonale ☐ Erythrocythemia (include hematocrit):

For cluster headaches, enter the date of neurological examination (*for initial requests only*):

Documentation of failed medication therapy (*for initial requests only*):

Flow rate (l/min.):	Hours of treatment per day (estimated):

Is oxygen therapy required for use within the home?	☐ Yes	☐ No
Is oxygen therapy required for traveling when leaving the home?	☐ Yes	☐ No
Client is compliant with oxygen usage as ordered in initial request (*for renewal requests only*):	☐ Yes	☐ No

Physician Signature

If requesting supplies only, I certify that the client owns his or her oxygen therapy device.

Prescribing Physician's Signature:	Date Signed: