

UTAH MEDICAID PRIOR AUTHORIZATION: OXYGEN

Provider Name and Number:	Provider's Phone/Fax #:
Client Name/ID #:	Client DOB:

HCPC codes Circle 1

E0424RR/stationary compressed gas O2 (1/month)	E0440/Stationary liquid O2 (purchase only)
E0425/Stationary compressed gas. (Purchase only)	E0441/O2 gas contents. Need L/min only.
E0431 RR/ Portable gas O2 (1/month)	E0442/Liquid O2 contents/to use with owned liquid stationary system. Need l/min only.
E0434RR/ Portable liquid O2 (1/month+must be on liq. stationary system)	E0443/Portable O2 contents, gas. See below.
E0439rr/ Stationary liquid O2 (1/month)	

In order for Medicaid to Prior Authorize Stationary/portable oxygen, the following information is required. Please complete this form with a copy of the physician's script and mail or fax to: Carol Rasmussen, RN Fax #801-536-0955.

Medicaid will cover portable oxygen for medical appointments only. This includes trips to the physician's office, occupational or physical therapy or speech therapy. TRANSPORTATION TO/FROM SCHOOL, MUST include specific total travel time/day.

Regular daily activity such as, shopping, church, etc is NOT a Covered Benefit (NAB) for Medicaid coverage.

The following information is required for E0443:

Prescribed oxygen liter flow: <div style="text-align: center;">LPM</div>	Daily hours required: <div style="text-align: center;">(e.g., 24 hr)</div>
Diagnosis:	Duration of Need:

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	<i>(Skip if same as above)</i>
Number of medical appointments per month:	Approximate duration of medical visit:
Approximate ROUND trip travel time:	

Please indicate any therapy (PT/OT/SP) or prescribed exercise necessary to improve condition

PHYSICIAN SIGNATURE:	DATE:
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