

# NIHB OXYGEN THERAPY AND RESPIRATORY THERAPY BENEFITS PRIOR APPROVAL FORM

Renewal

**Section 1: Patient Information** (to be completed by Regional Office)

Patient's Surname:			Date of Birth:
Given Name(s):			Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Band #:	Family #:	Telephone #:	Client ID#:

**Section 2: Physician Information** (to be completed by Physician)

Physician's Name:		License / Billing # :	Telephone #:
Physician's Signature:		Fax #:	
Diagnosis:		Complications: <input type="checkbox"/> Cor Pulmonale <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Secondary Polycythemia, indicate Hematocrit % _____	

**(FOR RESPIRATORY BENEFITS ONLY)**

**(FOR OXYGEN BENEFITS ONLY)**

**Section 3: Client Injury History** (to be completed by Physician)

**Section 4: Oxygen Prescription** (to be completed by Physician)

Is the benefit requested due to the result of an injury: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:			Rest	Exertion	~ Sleep
Where did the injury occur: Home <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/>	When did the injury occur:	Oxygen low rate, lpm			
Are any of these expenses covered under any other public or private health care plan: Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of hrs / day			

**Section 5: Arterial Blood Gas and / or Oxygen Tests** (to be completed by Physician) **(OXYGEN ONLY)** Signed and dated oxymetry test must accompany this form if PaO2 is greater than 55mmHg. Future signed and dated oxymetry tests may be requested by FNIHB for assessment. ABG results are required for initial oxygen set up, as well as the three month and one year assessments.

ABGs on room air: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, specify _____% flowrate.					Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)		
Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2	Rest	Exertion	Sleep
					Date:	Date:	Date:

**Section 6: Benefit Requested** (to be completed by Provider)

Description of Benefit	Benefit Code	Qty	Cost	MFR Name, MFR Item Code, Class Type and Serial #

**Section 7: Provider Information** (to be completed by Provider)

Provider Name:	Provider #:
Telephone #:	Fax#:

I hereby certify that the information is true and complete and that the oxygen equipment and information pertaining to that equipment have been provided to the above named client. The NIHB Program reserves the right to request this form for audit purposes.

Provider Signature:	Date:
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