PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Oxygen (O_2) REQUEST VERIFICATION FORM

Please attach patient reports verifying this information and document activity level and/or sleep during the exam.

Member Name: _____ PHC ID Number (CIN):_____

Date of Birth: _____ Physician: _____

1. What is the diagnosis for which the Oxygen is requested? _____

2. Date of O_2 Saturation test: _____

3. Is the O_2 request

Continuous use? _____

Supplemental use with activity? _____

Nocturnal use? _____

		YES	NO
4.	**For Continuous Requests:**		
	Is the Oxygen Saturation <89% awake and at rest? (*Testing must show that this is the usual resting saturation for the patient*.)	____	____
5.	**For Supplemental Requests:**		
	Is the Oxygen Saturation <89% during the 6-minute walk test? (*Testing must show that the patient has an Oxygen Saturation over 89% at rest that drops to under this value with exercise*.)	____	____
6.	**For Nocturnal Requests:**		
	Is Oxygen Saturation <89% for at least 5 minutes during sleep?	____	____

(*Testing must show that during sleep there is at least one continuous period of Oxygen Saturation <89% for at least 5 minutes. Cases where there are frequent drops of Oxygen Saturation to <89% but not in a continuous 5 minute period will be reviewed individually*.)

I have reviewed and concur with this information._____

Requesting Physician Signature/Please Also Print Name