NIHB OXYGEN AND RESPIRATORY PROGRAM PRIOR APPROVAL FORM

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

Patient's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:

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

Physician's Name:	License / Billing # :	Telephone #:
		Fax #:
Diagnosis:		Complications: ☐ Cor Pulmonale ☐ Pulmonary Hypertension ☐ Secondary Polycythemia, indicate Hematocrit % _____

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

Is the benefit requested due to the result of an injury: Yes ☐ No ☐ If **yes**, please complete the following:

Where did the injury occur: Home ☐ Work ☐ Other ☐

When did the injury occur:

Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

(OXYGEN ONLY)

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

	Rest	Exertion	Sleep
Oxygen low rate, 1pm			
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 ☐ No ☐ If no, specify _____% _____ flowrate.

Date	pH	PaO2 (mmHg)	PaCO2 (mmHg)	SaO2

Oximetry (SpO2) Test Results on Room Air (print outs of oximetry test results, signed and dated, must accompany this form)

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 and Class Type

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

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

I hereby certify that the information in Sections 5 and 6 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: