

Certification of Medical Necessity

**U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation**



Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care (30 U.S.C. 901 at seq. and 20 CFR 725.705 and 725.706). Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician. Collection of this information is required to obtain a benefit. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.:1215-0113
Expires:

1. & 2. Patient's Name and Mailing Address		3. Telephone Number	4. Social Security Number
name:			
line 1:	city:		5. Date of Birth
line 2:	state: zip:		

6a. Date(s) of last hospitalization	6b. Condition(s) treated while in hospital
From:	
To:	

7. Pulmonary Condition(s) for which this prescription is written:	8a. Type of Prescription	8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
	Original (New) Recertification (Renewal)	Beginning Date: Ending Date:

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11 b.)	Prescription: Flow Rate (L/M)	Est. Hrs./Day
Tank 02 With Flowmeter and Humidifier	02 Concentrator	02 Liquid System
Portable Unit (Gaseous)		02 Liquid System With Portable Liquid

9b. Other DME	9c. Prescription for Medical Services
Manual Hospital Bed (11 c.)	Pulmonary Rehabilitation Services (See 11 e.)
Semi-electric Hospital Bed (11 c.)	Level: _____
Nebulizer with Motor (11 a.)	Home Nursing Care (See 11 d.)
Wheelchair (11 f.)	
Other (Explain in item no. 12.)	

10. Objective Test Results -Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report.

(Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test	B. Check as appropriate (if "poor", explain in No. 12 'Additional Comments')
Date of test: Pt.'s condition:	Miner's Cooperation: Good Fair Poor
Results (Best Effort)	Miner's ability to understand instructions and follow directions:
	Good Fair Poor
	C. Was equipment calibrated before the test? Yes No
	D. Testing Facility Name and Address:
	name:
	line 1: city:
	line 2: state: zip:

E. Arterial Blood Gas Test	F. Air Intake: On room air On O ₂ @ _____ LPM
Date of test: Pt.'s condition:	G. Time Sample Drawn Iced Time Sample Analyzed
Results:	Yes
	No
	H. Was equipment calibrated before the test? Yes No
	I. Testing Facility Name and Address Name:
	line 1: city:
	line 2: state: zip:

