1199SEIU
Benefit and Pension Funds

National Benefit Fund • Health Care Employees Pension Fund
Greater New York Benefit Fund • Greater New York Pension Fund
Home Care Employees Benefit and Pension Funds • Home Health Aide Benefit Fund
330 WEST 42ND STREET | NEW YORK, NY 10036-6977 | WWW.1199SEIUBENEFITS.ORG

Care Management Department
Request for Home Oxygen Authorization

Fax completed form to (646) 473-7447.

Initial Request ☐ Renewal ☐

♦♦

1199SEIU Member's Name: ______________________________

Member ID: | | | | | | | | | | |

Patient (if not member): ______________________ Relationship to member: ❒ Self ❒ Spouse ❒ Child

Patient date of birth: ______ / ______ / ______ Age: _________

♦♦

Date of most recent office appointment: ______________________________

Any recent hospitalization relating to a respiratory condition? yes ❒ no ❒

If yes, hospital name & dates of service: ______________________________

HCPCS/CPT Code(s) & Description: ______________________________

____

____

ICD-9 Code(s) & Description:

Principal: ______________________________

Secondary: ______________________________

Type of Lab Test and Values While on Room Air

Name of Provider Completing Test ______________________

Patient's condition at test time: ❒ At Rest ❒ During Exercise ❒ During Sleep

Is patient ambulatory? ❒ Yes ❒ No

Member ID: ☐☐☐☐☐☐☐☐☐☐ Patient's Name: ______________________________

Anticipated duration of treatment ________________________ or ❐ Duration is lifetime

Liter Flow Rate ________________ (LPM) OR $F1O_2$ % ______________________

# of hours per day requiring O_2 __________________

If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM.

❐ ABG
Pa O_2 level _____ mm / Hg

❐ Pulse Oximetry
Oxygen saturation level ________ %

Date Test Completed: _____ / _____ / ______

Answer below **ONLY** if PO = 56-59 or oxygen saturation = 89

Does the patient have dependent edema due to congestive heart failure? ❐ Y ❐ N

Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement: ❐ Y ❐ N

Does the patient have a hematocrit greater than 56%? ❐ Y ❐ N

Name of Ordering/Treating Physician: ____

TIN # (Tax ID): ____________________________ Fax #: (______) ______ - ________

Physician Signature: ____ Date: ____ / ____ / _____

Physician Specialty:___________________________________ Telephone: (______) ______ - _______

Office Address: ____

____

Name of Facility/Vendor Providing Service: ____

TIN # (Tax ID #): ________________________ Fax Number: (______) ______ - ________

Address: ____

Vendor Authorized Signature: _________________Print Name: ________________Title: ___________________

Contact Person: _____________________________________ Title: ________________________________

Telephone: (______) ______ - _______

In order to process your request, the Provider TIN # & Fax #'s along with the CPT / HCPCS & ICD-9 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00AM – 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.