1199SEIU Funds
Benefit and Pension

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

Care Management Programs
Home Oxygen Request for Authorization

Fax completed form with supporting clinical documentation to (646) 473-7447

Request Submitted By _____ **Request Date** ____ / ____ / ____

☐ **INITIAL REQUEST** ☐ **RENEWAL**

1199SEIU MEMBER INFORMATION

Member Name _____ _____
Last Name First Name

Member ID | | | | | | | | | | |

PATIENT INFORMATION (*If not the Member*)

Patient Name _____ _____
Last Name First Name

Date of Birth ____ / ____ / ____

CPT/HCPCS Code(s) & Description

Code _____

Description _____

_____

ICD 10 Code(s) & Description

PRINCIPAL _____

Description _____

_____

SECONDARY _____

Description _____

_____

Member ID | | | | | | | | | |

Patient Name

Last Name _____ First Name _____

Test Results

- ☐ Recent ABGs
- ☐ PA O_2 Level _____ mm/Hg

OR

- ☐ Recent Pulse Oximetry _____
- ☐ Oxygen Saturation Level _____

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 **OR** ☐ Pulse Oximetry

PA O_2 Level _____ mm/Hg Oxygen saturation level _____%

Date Test Completed ____ / ____ / ____

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

Does the patient have dependent edema due to congestive Heart Failure?

☐ Yes ☐ No

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

☐ Yes ☐ No

Does the patient have a hematocrit greater than 56%?

☐ Yes ☐ No

Member ID | | | | | | | | | |

Patient Name

Last Name _____ First Name _____

PHYSICIAN INFORMATION *(Ordering/Treating Physician)*

Physician Name _____ **TIN** (*Tax ID*) _____

Physician Specialty _____ **Telephone** (____) ____ - _____

Fax (____) ____ - _____

Address _____

Street Name City State Zip Code

Physician Signature _____ **Date** _____ / _____ / _____

FACILITY/VENDOR INFORMATION *(Facility/Vendor providing the service)*

Facility/Vendor Name _____

TIN *(Tax ID)* _____ **Telephone** (____) ____ - _____

Fax (____) ____ - _____

Address _____

Street Name City State Zip Code

Vendor Authorized Signature _____

Name _____ **Title** _____

Please print clearly

Contact Person _____ **Title** _____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD 10 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. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 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.