


**CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
ENTERAL**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  3519 Industrial Avenue Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1267160002	Patient Name, Address, Telephone & HIC#: () - HIC#: . Patient DOB: / / Sex: (M/F)
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An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by: _____

ENTERAL:

Date of Service: _____
 Diagnosis and Code: _____
 Length of Need (# of months): _____ 1-99 (99=life)
 Patient Height: _____ ft. in. Weight: _____ lbs.
 BMI: _____
 Date of discharge from the hospital: _____

Tube Type:

- Gastrostomy (G) Tube
 - Jejunostomy (J) Tube
 - Nasogastric (NG) Tube
- Size: _____ Type: _____

Formula:

Formula Type #1: _____
 Calories / day _____
 Formula Type #2: _____
 Calories / day _____
 Formula Type #3: _____
 Calories / day _____

Deliver Method:

- Oral (i.e. drinking)
- Syringe (Bolus)
- Gravity
- Pump

Settings:

Feed Rate (mL/hour): _____
 Flush (mL/hour): _____
 Total Volume: _____

Special Instructions: _____

Other Supplies:

- Gauze (each) _____ per month
- Feeding Bags _____ per month
- Syringes, Catheter Tip _____ per month
- Extension Tube, Enteral (B9998) _____ per month
- IV Pole (Required for Gravity and Pump Method)

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient have a permanent non-functioning or disease of the structures that normally permit food to reach or be absorbed from the small bowel?
 Y N
2. Day(s) / week administered (1-7) _____
3. Does the patient require replacement of the feeding tube on a routine basis?
 Y N
 Specific Frequency: _____
4. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall status?
 Y N
5. Is this the patient's sole source of nutrition?
 Y N
6. What percent (%) of the patient's daily intake does the formula constitute? _____
7. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?
 Y N

If pump is ordered

8. Patient must meet at least one of the following to qualify.
 - Aspiration, reflux, or Dumping Syndrome
 - Severe diarrhea remedied by regulated feeding
 - Administration rate less than 100ml/hour
 - To regulate blood glucose fluctuations
 - Patient has congestive heart failure and requires a pump to prevent circulatory overload
 - Patient has a jejunostomy tube for feeding

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

 Provider's Signature Date

 Provider's Name

NPI: _____ Telephone: _____