℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
ENTERAL

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** Suite 106 **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

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:

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 1 every 3 months
☐ Jejunostomy (J) Tube 1 every 3 months
☐ Nasogastric (NG) Tube 1 every 3 months

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) Qty: _____ Size _____
☐ Gravity
☐ Pump

Settings:

Feed Rate (mL/hour): _____
Total Volume to be fed: _____
Flush (mL/hour): _____
Special Instructions: _____

Other Supplies:

☐ Gauze (each) 60/month Size _____
☐ Feeding Bags 31/month ☐ 500ml ☐ 1000ml ☐ Flush & Feed
☐ Syringes, Catheter Tip_____ per month Size _____
☐ Extension Tube, Enteral (B9998) 4/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: _____