

Enteral Nutrition Certificate of Medical Necessity, Page 1 of 2

MEMBER INFORMATION		ORDERING PROVIDER INFORMATION	
Member Name: _____ (Last, First, MI) Alaska Medicaid Member ID: _____ Date of Birth (MM/DD/YY): _____ Age: _____		Ordering Provider's Name: _____ Provider Medicaid ID or NPI: _____ Phone Number: _____ Ext. _____	
Type of Request <input type="checkbox"/> Initial Request <input type="checkbox"/> Revised Prescription – Authorization ID _____ <input type="checkbox"/> Prescription Renewal			
CLINICAL INFORMATION (This section MUST be completed by the ordering physician, physician assistant, or nurse practitioner.)			
Date of Last Physician Visit Related to Nutrition		ICD-10 Diagnosis Codes (Enter all Dx related to need for enteral nutrition therapy.)	
Answer Questions 1 – 6 (Y = Yes, N = No)			
1. INITIAL REQUESTS ONLY – Are enteral products needed to discharge from hospital setting?			Y or N Discharge Date: _____
2. UNDER 21 YRS – Consultation with registered dietician or licensed nutritionist in last 12 months? <i>* Consultation may be through the Alaska WIC Nutrition Program or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.</i>			Y or N Consult Date: _____
3. Do member's medical records demonstrate a non-function or disease of the structures that normally permit food to reach the small bowel or disease of the small bowel which impairs digestion and absorption of an oral diet? <i>May be anatomic condition or motility disorder.</i>			Y or N
4. Do member's medical records demonstrate that the member is unable to obtain sufficient caloric and protein intake from any regular, liquefied, or pureed foods?			Y or N
5. Are enteral needs the result of a temporary condition that will be fully resolved within 3 months?			Y or N
6. ORAL REQUESTS – Does member reside in an assisted living home (ALH) or long-term care (LTC) facility?			N or ALH or LTC
Height	Weight	Target Weight	
Daily Caloric Intake Requirements			
Total Calories: _____ Calories from Ingested Foods/Liquids: _____ Calories from Enteral: _____			
Route of Administration (Check all that apply.) <input type="checkbox"/> Syringe <input type="checkbox"/> Gravity <input type="checkbox"/> Pump * <input type="checkbox"/> Oral <i>* If requested, medical records must support necessity of pump over syringe/gravity method.</i>			Number of Monthly Refills (1 - 11 Months)
REQUESTED NUTRITIONAL PRODUCTS (This section MUST be completed by the ordering physician, physician assistant, or nurse practitioner.)			
Nutritional Product Description	Calories / Quantity	Frequency (i.e., per day, per hour)	
Supply Needs and/or Additional Feeding Instructions			
ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN / PHYSICIAN ASSISTANT / NURSE PRACTITIONER			
A physician, physician assistant, or nurse practitioner who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.			
Signature of Ordering Physician / Physician Assistant / Nurse Practitioner			Date

Authorization does not guarantee payment. Payment is subject to member's eligibility. Check that identification card is current before rendering services.

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