


ENTERAL NUTRITION & SUPPLIES STANDARD WRITTEN ORDER

 <p style="margin: 0;">Please fax to: Anchorage (907) 274-0773 Fairbanks (907) 458-8914 Soldotna (907) 260-3757 Wasilla (907) 357-7883 or email to: dme@procarehm.com</p>	Patient Name, Address, Telephone & Insurance ID#: Phone: _____ Ins ID#: _____ Patient DOB: _____ Sex: (M/F)
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Please refer to Enteral coverage criteria sheet for all required documentation.

ENTERAL:

Date of Last Visit: _____

Diagnosis and Code: _____ Patient Height: _____ in. Weight: _____ lbs.

Length of Need (# of months): _____ 1-99 (99=life)

Formula:

Formula Type #1: _____ Substitution Allowed Calories per day: _____

Formula Type #2: _____ Substitution Allowed Calories per day: _____

Deliver Method: Oral (i.e. drinking) Syringe (Bolus) Gravity Pump

Pump Settings: Feed Rate(mL/hour): _____ Flush (mL/hour): _____ Total Volume to be fed: _____

Gravity: _____ mLs/hr _____ hours or _____ times per day

Syringe: _____ mLs/hr _____ hours or _____ times per day

Tube Type: Gastrostomy (G) Tube 1 every 3 months

Jejunostomy (J) Tube 1 every 3 months

Nasogastric (NG) Tube 1 every month

ENFit

Size: _____ Standard Low Profile

Supplies:

Feeding Pump with IV Pole

Syringes 30/mo may select multiple sizes 20mL 60mL

Gauze (each) select one size 2x2 70/mo 4x4 50/mo

Tape 1/month Waterproof Non-Waterproof

Extension Sets 4/mo

Feeding Bags 30/month

IV Pole (required for Gravity Method)

Feeding Pump Backpack

Other: _____

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: _____ NPI: _____

Provider's Name: _____ Telephone: _____