

Select One:
 Initial Certification (3 months)
 First Recertification (6 months)
 Yearly Recertification (12 months)

ENTERAL NUTRITION REQUEST FORM

Fax to: Toll Free (866) 825-2884

Children Under 5 Years, Pregnant and Postpartum Women Must FIRST Register with the Federal Program for Women, Infants and Children (WIC). A Copy of the WIC Statement MUST be attached to this Form.

PHYSICIAN COMPLETE THIS SECTION – REQUIRED INFORMATION

Member ID# _____ DOB ____/____/____
 First name _____ M.I. _____ Last Name _____
 Prescriber Name _____ Specialty _____
 Contact Person _____ Prescriber Phone (____) _____ Prescriber Fax (____) _____
 Food supplement requested: _____
 QTY _____ Cans/Scoops/Pkts Per Day _____ Length of Therapy _____
 Diagnosis _____ ICD-9 _____
 Dosage and Frequency of dosing _____ Daily Caloric intake requirement _____
 Route of Administration: Oral G- Tube Feeds NG Tube Jejunostomy Tube Feeds
 Height and Weight (required) _____ft _____in _____ lbs Date measured ____/____/____
 Comments _____

Is this formula the only form of nutritional intake for this member? Yes No
 Is this formula necessary in order to prevent mental retardation? Yes No
 Is the formula necessary in order to sustain life? Yes No

Consultation with a Registered Dietician? Yes No Date _____ RD Name _____

*** Required **Physician Certification Statement** ***
 "I hereby certify that, without this food supplement, this patient will require institutionalization."

Signature _____ Date _____

Please attach a copy of the original prescription. Attach lab results and other documentation as necessary.

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