

Certificate of Medical Necessity: Parenteral or Enteral Nutrition

Section A Initial Revised Recertification

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| Patient Name, Address Phone #(_ _ _) _ _ _ - _ _ _ _ HICN # _____ | Supplier Name, Address Phone #(_ _ _) _ _ _ - _ _ _ _ NSC# _____ |
| Place of Service _____ Replacement Item _____ Name and Address of Facility if applicable: _____ | HCPCS Code(s) _____ Warranty _____ Length _____ Type _____ |

Section B Clinical Information

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| Diagnosis (ICD9): _____ I last examined this patient for this condition on: _____ Pt Sex _____ (M or F) | Pt Ht _____ (In.) Pt Wt. _____ (Lbs) DOB ____/____/____ Date Needed Init ____/____/____ Rev/Recert ____/____/____ Est. Length of Need: # of Months: _____ 1-99 (99 – Lifetime) |
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Answer Questions 1-6 for Parenteral, answer 2, 6-15 for Enteral Use Y – Yes, N – No or D – Does Not Apply, unless otherwise noted.

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| { } 1. Does the patient have severe permanent disease of the gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? { } 2. Do the number of calories prescribed average 20-35 cal/kg/day? { } 3. Days per week infused? Enter 1-7 4. Formula components: Amino acid _____ (ml/day) _____ concen% _____ gms protein/day Dextrose _____ (ml/day) _____ concen % Lipids _____ (ml/day) _____ days/week _____ concen% { } 5. What is the route of administration? 1 – Central Line 2 – Peripheral line 3 – Hemodialysis access line 7 – Peripherally inserted central catheter (PICC) { } 6. Has there been a break in therapy of two or more consecutive months, necessitating a new certification, during which time the patient did not receive enteral or parenteral feeding? { } 7. Does the patient have permanent nonfunction or disease of the structures that normally permit food to reach the small bowel? | { } 8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? { } 9. What is the prescribed route of administration? 4 – Nasogastric tube 5 – Gastrostomy tube 6 – Jejunostomy tube 10. Product name? _____ 11. Calories per day? _____ { } 12. Days per week administered? Enter 1-7 { } 13. Method of administration? 1 – Syringe 2 – Gravity 3 – Pump { } 14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? 15. Additional information when required by policy: _____ |
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I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereto has been completed by me or reviewed by me. The foregoing information is true, accurate and complete, I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

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| Physician Name, Address | Physician's Signature: _____ Date ____/____/____ (Stamped Signature is NOT Acceptable) <input type="checkbox"/> Attending <input type="checkbox"/> Consulting <input type="checkbox"/> Other ordering UPIN: _____ Telephone #: (_____) _____ - _____ |
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