

PHYSICIAN ORDER (LETTER OF MEDICAL NECESSITY)

Patient: _____ DOB: _____

Address: _____ Phone: _____

Length of need: _____ Calories per day: _____

Diagnosis Code (ICD-9): _____
_____, _____, _____, _____

METHOD OF ADMINISTRATION: ☐ Syringe ☐ Gravity ☐ Pump ☐ Oral (not Medicare Benefit)

NUTRITIONAL PRODUCT: _____

Enteral Feeding Supply Kit	
B4034	Syringe Supply Kit (30 per mth.)
B4035	Pump Supply Kit, Enteral feeding bags (30 per mth.)
B4036	Gravity Supply Kit (30 per mth.)
A4322	Irrigation Syringe -60cc
Enteral Feeding Pumps & Pole	
B9002	Enteral pump with alarm
E0776	IV Pole

1. Is the enteral nutrition being provided for administration via gastrostomy tube? ☐ YES or ☐ NO
2. Does the patient require tube feeding to provide sufficient nutrients to maintain weight? ☐ YES or ☐ NO
3. Does patient have a permanent non-function or disease of the structures that normally permit food to reach the small bowel; or a permanent disease of small bowel which impairs digestion and absorption of an oral diet? ☐ YES or ☐ NO
4. Patients only source of nutrition? ☐ YES or ☐ NO
5. Days per week administered or infused (ENTER 1 – 7): _____

I certify that I am the physician identified in this form. I have received the letter of medical necessity. Any statement on my letterhead hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge.

Prescribing Physician: _____

Physician Signature : _____ Date: _____

DME INFORMATION FORM

CMS-10126 — ENTERAL AND PARENTERAL NUTRITION

DME 10.03

All INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER			
Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___			
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (___-___) ___-___-___ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (___-___) ___-___-___ NSC or NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB _____ Sex ___ (M/F) Ht. ___ (in) Wt. ___ (lbs.)	
NAME and ADDRESS of FACILITY if applicable (see reverse)		PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (___-___) ___-___-___ UPIN or NPI # _____	
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____	
ANSWERS	ANSWER QUESTIONS 1–6 FOR ENTERAL NUTRITION, AND 6 - 9 FOR PARENTERAL NUTRITION (Circle Y for Yes, N for No, Unless Otherwise Noted)		
Y N	1. Is there documentation in the medical record that supports the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?		
Y N	2. Is the enteral nutrition being provided for administration via tube? (i.e., gastrostomy tube, jejunostomy tube, nasogastric tube)		
A) _____ B) _____	3. Print HCPCS code(s) of product.		
A) _____ B) _____	4. Calories per day for each corresponding HCPCS code(s).		
1 2 3 4	5. Circle the number for method of administration? 1 – Syringe 2 – Gravity 3 – Pump 4 – Oral (i.e. drinking)		
_____	6. Days per week administered or infused (Enter 1 – 7)		
Y N	7. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?		
8. Formula components: Amino Acid _____ (ml/day) _____ concentration % _____ gms protein/day Dextrose _____ (ml/day) _____ concentration % Lipids _____ (ml/day) _____ days/week _____ concentration %			
1 2 3	9. Circle the number for the route of administration. 1 – Central Line (Including PICC) 2 – Hemodialysis Access Line 3 – Peritoneal Catheter		
Supplier Attestation and Signature/Date			
I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.			
SUPPLIER SIGNATURE _____ DATE ___/___/___			