ALLSTATE DME LLC
4949 N. McColl Rd. McAllen, TX 78504
Phone (956) 992-8866 Fax (956) 287-8586

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 10.03

DME INFORMATION FORM
CMS-10126 — ENTERAL AND PARENTERAL NUTRITION

All INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER 1982847992
(__ __ __) __ __ __ - __ __ __ __ HICN _____	ALLSTATE DME LLC 4949 N. MCCOLL RD. (956) 992-8866 - __ __ __ __ NSC or NPI # 1982847992
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 _____/_____/_____