



ALLSTATE DME LLC
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 Provider No. 6385310001

PHYSICIAN ORDER FOR ENTERAL NUTRITION

Patient: _____ DOB: _____
 Address: _____ Phone: _____

 Physician: _____ Phone: _____
 Address: _____
 Initial Date: _____ Length of need: _____
 Diagnosis Code (ICD-9): _____, _____, _____, _____
 PRODUCT: _____ CALORIES PER DAY: _____

METHOD OF ADMINISTRATION?

_____ Syringe _____ Gravity _____ Pump _____ Oral (not Medicare Benefit)

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

DAYS PER WEEK ADMINISTERED OR INFUSED (ENTER 1 – 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?
 _____ Yes _____ No

I certify that the information provided is true, accurate and complete, to the best of my knowledge.

 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 <i>if applicable (see reverse)</i> _____ _____ _____	_____ _____ _____	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 ___/___/___		

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR ENTERAL AND PARENTERAL NUTRITION (CMS-10126)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO.:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see <http://www.medicare.gov/> for information on claim filing.