



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

## Oral Enteral Nutrition Request Form- Ohio Medicaid

**Fax to: Toll Free (868) 881-8225**

**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 Requests Only

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.*

<b>For Internal Use Only</b>

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

**FAX to: Kentucky Medical Authorizations (868) 881-8225**