



Select One: <input type="checkbox"/> Initial Certification (3 months) <input type="checkbox"/> First Recertification (6 months) <input type="checkbox"/> Yearly Recertification (12 months)

Oral Enteral Nutrition Request Form- Ohio Medicaid

Fax to: Toll Free (877) 277-6892

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.

For Internal Use Only	
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Ohio Department of Jobs and Family Services
Certificate of Medical Necessity/Prescription
Enteral Nutrition Services

Medicaid Supplier/Pharmacy Provider Name						Provider NPI and Medicaid Legacy Number			
SECTION A CERTIFICATION TYPE (To be completed by medical supplier/pharmacy provider)									
INITIAL Prescription Date			RECERTIFICATION PA #				REVISED PA #		
Change in prescriber order? Y N If Yes, provide previous formula and # of calories per day						End date for previous PA Number of units billed			
1. Consumer Name								Consumer Date of Birth	
Note: WIC program provides formula for children age 5 and under. 2. Is the recipient receiving nutritional supplement(s) from WIC? Yes No									
If yes, specify product(s) and amount supplied by WIC.						Product(s)		Amount	
SECTION B PRESCRIBER CERTIFICATION/PRESCRIPTION (Must be completed by Prescriber)									
3. Diagnosis(es) [ICD-9 Code and Description]									
4. Does the consumer have an absorption problem, swallowing dysfunction, obstruction or require tube-feeding? If "Yes", explain Yes No									
5. If you answered "No" to #4, please explain why enteral nutrition is required. List lab values in #7, if applicable.									
6. If you answered "No" to #4, AND the consumer is unable to maintain weight on regular food, provide weight history.									
Date	Current Weight		Height	Date	Weight	Date	Weight	Date	Weight
7. If you answered "No" to #4, AND lab values indicate nutritional deficiency, please provide all applicable lab results. List name of test, value and date or attach a copy of current lab results.									
8. Length of Need Number of Months Note: Maximum approval period is 12 months. Recertification is required annually.									
9. Prescribed enteral product and calorie requirements. Note: If daily calorie requirements exceed 2000, please explain. Product Calories Per Day									
10. Enteral Administration Supplies (Must Be Completed for Tube Feedings): Pump Gravity Farrell Valve Bolus Ext. sets									
11. Number of calories per can					12. Number of cans per case				
Prescriber Name (Printed)									
I certify that I am the prescriber identified above. I certify that the information in Sections A and B of this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability.									
Prescriber's Signature (No stamps)								Date	
Prescriber's NPI and Medicaid Legacy Number					Prescriber's Area Code and Phone Number				

Prior Authorization/ Medical Necessity Documentation Requirements

The purpose of these guidelines is to define the written documentation required to assist the department in determining the medical necessity for enteral nutrition. This information, including the order for the specific enteral nutrition product and calorie requirements, must be in the form of a complete and signed physician certificate of medical necessity. Medicaid providers will use the ODJFS "Certificate of Medical Necessity/Prescription, Form JFS 01907 (Rev. 3/2008)" for all enteral nutrition requests.

General Guidelines

- Initial requests for enteral products may be authorized for periods up to 12 months.
- When documenting medical necessity, please be specific when describing the medical need for the enteral nutrition. Avoid using general statements about the patient's health status.
- Always provide the current prior authorization number and authorized date spans when requesting certification or a revision to an existing prior authorization.
- Medical suppliers/pharmacies must complete Section A of the certificate of medical necessity.
- Prescribers must complete Section B of the certificate of medical necessity.

Documentation of Medical Necessity

Documentation of medical necessity must include all applicable diagnoses. Provide the **ICD-9** code and a **written description**; failure to provide both may delay processing of the prior authorization request. In addition to the diagnosis, submit information that supports the need for the nutritional supplement. A diagnosis and brief written description of the consumer's condition will generally be sufficient documentation for those consumers who require tube feedings as their sole source of nutrition, or have a disease/condition that prevents adequate absorption of sufficient nutrition from regular food.

For those consumers who do not meet the aforementioned criteria, documentation must include (in addition to specifying all applicable diagnoses) justification for why the enteral nutrition is required. If a patient cannot maintain weight, provide a weight history documenting the weight loss. Lab values which document nutritional deficiencies (e.g. albumin) should also be provided (general rule-of-thumb: if lab values are available, document them). The certificate of medical necessity **must** specify the daily calorie requirements to be supplied by the enteral product. Note: Please provide an explanation when daily calorie requirements exceed 2000.

WIC

The Women, Infants and Children (WIC) program will cover formula for children ages 0 to 5. Consumers must obtain enteral products for these children from WIC prior to requesting coverage through Medicaid. WIC coverage is limited to a select number of formula products. If WIC does cover the ordered formula, but does not supply the total amount required, Medicaid will consider coverage of the difference. When the ordered formula is not covered by WIC, it may be considered for coverage by Medicaid.

Billing

Use the appropriate alpha-numeric HCPCS code as listed in OAC code 5101: 3-10-03. **Do not use NDC numbers.** Providers are to dispense and bill for authorized enteral products on a monthly basis. Payment will be contingent upon recipient eligibility.