Ohio Department of Medicaid

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? ☐ Yes ☐ No 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? ☐ Yes ☐ No
If "Yes", explain

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