Oral Nutrition Prescription Form/Letter of Medical Necessity

Phone: 215-743-1100 & 800-344-1550 Fax: 844-317-9379

***Orders MUST Include the following information with this form;**

- ***Patient Demographics with Insurance Information***
- ***Food Logs, Lab Work, clinical notes and/or any other relevant documentation***

Patient Name_____ **Male** [ ] **Female** [ ] Date of Birth_____

*Preferred Language*_____ Patient Cannot Accept Deliveries on the following days (circle) *Mon Tues Wed Thu Fri Sat*

Primary Diagnosis (Required)	***Secondary Diagnosis (Required)****
*ICD-10 Code:*_____	*ICD-10 Code:*_____ **Diagnosis must reinforce medical necessity & justification of nutritional products.*

Height:_____ Weight:_____ 3 Months ago_____6 Months ago_____ 9 Months ago_____

Body Mass Index(BMI)_____ Caloric Needs/Day_____ Goal Weight:_____ Albumin:_____

Nutritional History:

Have any previous attempts been made to treat with: (check all that apply)?

____ *High Calorie* ____ *High Protein* ____ *Regular Foods* ____ *Regular Foods (blenderized)*

**What were the results of these attempts?*_____

_____

Has the patient received any nutritional supplements in the past? (circle one) YES NO If so, did the patients gain weight? (circle one) YES NO

Dietitian History

Has the patient been referred to a dietitian/nutritionist? (circle one) YES NO Name_____

*Please provide details why can needs not be met utilizing ordinary food with assistance of dietician/nutritionist?_____

_____

Product(s): _____ [ ]_____

Dosage: ***Amount Intake_____Cans*** *(or ml, if necessary)* ***Frequency****(circle One)* ***QD BID TID QID Other:_____***

Order Date _____/_____/_____ Start Date _____/_____/_____ Length of Need_____ Months No. of Refills_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that maybe disclosed. I certify that my decision to prescribe this recommended product was based solely based on my determination of medical necessity set forth herein.

Facility Name_____ Contact Person_____

Phone # _____ Fax#_____ Email_____

Address _____

Prescriber (Please Print)_____ NPI #_____ License #_____

Prescriber Signature_____ **Date** _____/_____/_____ Pecos Certified *(circle one) Yes No*

**Pennsylvania Medicaid Patients must have a signature from an MD or DO*

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