Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Enteral Nutrition

Date: ____/_____/_____ **Requesting Provider: _____**

Pt. Name: _____ **I.D. Number: _____**

1. What diagnosis/condition does the patient have to warrant the use of Enteral Nutrition?

2. Does the patient have permanent non-function or disease of the structures that normally permit food to **reach** or be **absorbed** from the small bowels? Y N D

3. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patients overall health status? Y N D

   If yes, what % of calories to be provided by enteral formula? _____%

   Please specify product name(s): 1) _____

   2) _____

4. Calories per day for each product: 1) _____

   2) _____

5. Days per week administered: ____

6. Circle the number for method of administration:

   1 = Syringe 2 = Gravity 3 = Pump 4 = Does not apply

7. Does the patient have a documented allergy or intolerance to any semi-synthetic nutrients? Y N D

8. If special formulation required, provide specific details supporting medical necessity.

Contact Name: _____ **Phone :_____**

_____ _____

Physician Signature (Stamps are not acceptable) **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:
1. Typed office note with pertinent information.