

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.