| **MEMBER INFORMATION** | **ORDERING PROVIDER INFORMATION** |
|---|---|
| Member Name: _____ *(Last, First, MI)* | Ordering Provider's Name: _____ |
| Alaska Medicaid Member ID: _____ | Provider Medicaid ID or NPI: _____ |
| Date of Birth *(MM/DD/YY)*: _____ Age: _____ | Phone Number: _____ Ext. _____ |

**Type of Request** ☐ Initial Request ☐ Revised Prescription – Authorization ID _____ ☐ Prescription Renewal

**CLINICAL INFORMATION** *(This section **MUST** be completed by the ordering physician, physician assistant, or nurse practitioner.)*

| **Date of Last Physician Visit Related to Nutrition** | **ICD-10 Diagnosis Codes** (*Enter all Dx related to need for enteral nutrition therapy.)* |
|---|---|
| | |

**Answer Questions 1 – 6** *(Y = Yes, N = No)*

| | |
|---|---|
| 1. *INITIAL REQUESTS ONLY* – Are enteral products needed to discharge from hospital setting? | **Y** ☐ or ☐ **N** *Discharge Date:* _____ |
| 2. *UNDER 21 YRS* – Consultation with registered dietician or licensed nutritionist in last 12 months? ** Consultation may be through the Alaska WIC Nutrition Program or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.* | **Y** ☐ or ☐ **N** *Consult Date:* _____ |
| 3. Do member's medical records demonstrate a non-function or disease of the structures that normally permit food to reach the small bowel or disease of the small bowel which impairs digestion and absorption of an oral diet? *May be anatomic condition or motility disorder.* | **Y** ☐ or ☐ **N** |
| 4. Do member's medical records demonstrate that the member is unable to obtain sufficient caloric and protein intake from any regular, liquefied, or pureed foods? | **Y** ☐ or ☐ **N** |
| 5. Are enteral needs the result of a temporary condition that will be fully resolved within 3 months? | **Y** ☐ or ☐ **N** |
| 6. *ORAL REQUESTS* – Does member reside in an assisted living home (ALH) or long-term care (LTC) facility? | **N** ☐ or **ALH** ☐ or **LTC** ☐ |

| **Height** | **Weight** | **Target Weight** |
|---|---|---|
| | | |

**Daily Caloric Intake Requirements**

Total Calories: _____ Calories from Ingested Foods/Liquids: _____ Calories from Enteral: _____

**Route of Administration** *(Check all that apply.)*

☐ Syringe ☐ Gravity ☐ Pump * ☐ Oral

***** If requested, medical records must support necessity of pump over syringe/gravity method.

**Number of Monthly Refills** *(1 - 11 Months)*

**REQUESTED NUTRITIONAL PRODUCTS** *(This section **MUST** be completed by the ordering physician, physician assistant, or nurse practitioner.)*

| **Nutritional Product Description** | **Calories / Quantity** | **Frequency** *(i.e., per day, per hour)* |
|---|---|---|
| | | |
| | | |
| | | |

**Supply Needs and/or Additional Feeding Instructions**

**ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN / PHYSICIAN ASSISTANT / NURSE PRACTITIONER**

A physician, physician assistant, or nurse practitioner who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____

Signature of Ordering Physician / Physician Assistant / Nurse Practitioner Date

Authorization does not guarantee payment. Payment is subject to member's eligibility. Check that identification card is current before rendering services.