Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
ENTERAL AND PARENTERAL NUTRITION

SECTION A **Certification Type/Date: INITIAL**____/____/____ **REVISED**____/____/____ **RECERTIFICATION**____/____/____

PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER
(___) ___ - ____ MEMBER# _____	(___) ___ - ____ NSC OR NPI # _____
PLACE OF SERVICE / HCPCS CODE	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___ (in) Wt. ___ (lbs.)
NAME and ADDRESS of FACILITY *If applicable*	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER
	(___) ___ - ____ NSC OR NPI # _____

SECTION B Information in this Section **May Not Be** Completed by the Supplier of Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) DIAGNOSIS CODES : _____ _____ _____ _____

ANSWERS	QUESTIONS 1-5 FOR ENTERAL NUTRITION, AND 6-9 FOR PARENTERAL NUTRITION (Circle Y for yes, N for no, unless otherwise noted)
Y ☐ N ☐	1. Is there documentation in the medical record that supports the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?
Y ☐ N ☐	2. Is the enteral nutrition being provided for administration through a tube? (i.e. gastrosomy tube, jejunostomy tube, nasogastric tube)
A) _____ B) _____	3. Print HCPCS code(s) of product.
A) _____ B) _____	4. Calories per day for each corresponding HCPCS code(s).
1 ☐ 3 ☐ 2 ☐ 4 ☐	5. Circle the method of administration: 1 - Syringe 2 - Gravity 3 - Pump 4 - Oral (i.e. drinking)
_____	6. Days per week administered or infused (Enter 1 - 7)
Y ☐ N ☐	7. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?
	8. Formula components: Amino acid _____ (ml/day) _____ concentration % _____ gms protein/day Dextrose _____ (ml/day) _____ concentration % _____ Lipids _____ (ml/day) _____ days/week _____ concentration %
1 ☐ 2 ☐ 3 ☐	9. Circle the number for the route of administration. 1 - Central line (including PICC) 2 - Hemodialysis Access Line 3 - Peritoneal Catheter

To expedite timely review, medical records to support the above statement must be submitted at the time of request.

Name of the person answering section B questions, if other than the physician (PLEASE PRINT):

Name:_____ Title:_____ Employer: _____

SECTION C **Narrative Description of Equipment and Cost.**

(1) Narrative description of all items, accessories, and options ordered; (2) Supplier's charge.

SECTION D **PHYSICIAN Attestation and Signature / Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B, C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may be subject to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE _____