CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 782 (3-2012)

Clear Fields

ORAL AND/OR ENTERAL NUTRITION

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

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

Estimated Length of Need (Number of Months): 1-99 (99=Lifetime)	
1. Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? ☐ Yes ☐ No	
2. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status? ☐ Yes ☐ No	
3. Print product name(s).	
4. Total number of units per month.	
5. Will this consist of 51% or more of their daily nutritional intake? ☐ Yes ☐ No	B4154 Products Only: Will this consist of 90% or more of their daily nutritional intake? ☐ Yes ☐ No
6. Select the method of administration. ☐ Syringe ☐ Gravity ☐ Pump* ☐ Oral	
7. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? ☐ Yes ☐ No ☐ Does Not Apply	

* If an enteral pump is ordered, documentation is required to accompany the prior authorization to support pump therapy (example: gravity feeing is not satisfactory due to reflux and/or aspiration, severe diarrhea, clumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, gastrosotomy/jejunostomy tube used for feeding, circulatory overload.

SECTION C - Narrative Description

Narrative descriptions of all items, accessories and options ordered.

SECTION C Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)