# Enteral Nutrition Order

**PHONE NUMBER: 866-388-3883 | FAX NUMBER 888-249-3132**

**Demographics**

**Order Date**_____ **Start Date** _____

**Patient Name**_____**M**_____**F**_____ **DOB**_____**Ht**_____**Wt**_____

**Required Documentation:**

- **Patient Demographics**
- **Patient Height and Weight**
- **Insurance**
- **Medication List**
- **Clinical's documenting Enteral Nutrition Medical Necessity**
  **Note: Length of Need must be at least (3) Months or Longer**
  **Enteral Nutrition must be at least 50% of nutritional need and not considered supplemental**
- **Swallow Study**
- **Physician Signed/Dated Order**

**DX/LON**

**Length of need** ☐ **Lifetime** ☐ **Other**_____

☐ Dysphagia R13.10 ☐ CVA Late Effect I69.998 ☐ Aspiration/Vomiting J69.0 ☐ Other_____

**Nutrition**

☐ **Diabetisource (B4154)** ☐ **Jevity 1.2 (B4150)** ☐ **Osmolite 1.2 (B4150)**

☐ **Fibersource (B4150)** ☐ **Jevity 1.5 (B4152)** ☐ **Osmolite 1.5 (B4152)**

☐ **Isosource 1.5 (B4152)** ☐ **Two Cal HN (B4152)**

☐ **Other**_____

_____ **Cans per Day x 30 days x 12 Refills**
_____ **Calories per Day x 30 days x 12 Refills**

☐ **Equivalent substitutions permitted**

**Supplies**

☐ **Enteral Pump (B9002) with IV Pole (E0776) Rate**_____**Hrs per day**_____
☐ **Enteral Pump Bags (B4035) 1 mo = 30 Qty x 12 refills**
☐ **Syringes or Bolus Feeding (B4034) 1 mo = 30 Qty x 12 refills**
☐ **Gravity Bags (B4036) with IV Pole (E0776) 1 mo = 30 Bag Qty x 12 refills**
☐ **Other Prescribed Supplies**_____

**Physician**

Physician Name_____ Phone #_____

Address_____ Fax #_____

City, State, Zip_____ **NPI**_____

**Physician Signature** (no stamps allowed)_____**Date**_____