STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES
MEDICAID PROGRAM

CERTIFICATE OF MEDICAL NECESSITY for ENTERAL AND PARENTERAL NUTRITION

1. DME PROVIDER IS RESPONSIBLE FOR SUBMISSION OF COMPLETED FORM
2. DME PROVIDER TO ATTACH RI MEDICAID PA FORM
   HTTP://WWW.EOHHS.RI.GOV/PORTALS/0/UPLOADS/DOCUMENTS/PA_FORM.PDF
3. DME PROVIDER TO MAIL ORIGINALS TO:
   DXC TECHNOLOGY
   PO 2010, WARWICK, RI 02887

   OR FAX TO:
   401-784-3892
   ATTENTION: PRIOR AUTHORIZATION

SECTION A: TO BE COMPLETED BY DME PROVIDER. PLEASE PRINT INFORMATION

BENEFICIARY'S NAME: _____ TODAY'S DATE: _____

MEDICAID ID NUMBER: _____ BENEFICIARY'S DOB: _____

DME PROVIDER NAME: _____

DME PROVIDER CONTACT NAME: _____ PHONE: _____

HCPCS CODE: _____

PRINT ORDERING PRESCRIBER'S NAME: _____ NPI: _____

SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER. PLEASE ATTACH ANY SUPPORTING MEDICAL DOCUMENTATION AS NECESSARY. IF PRESCRIBING ENTERAL NUTRITION, COMPLETE THE SECTION BELOW. IF PRESCRIBING PARENTERAL NUTRITION, COMPLETE THE SECTION ON PAGE 2.

ENTERAL NUTRITION

BENEFICIARY'S NAME: _____ BMI: _____

DIAGNOSIS: _____

DESCRIPTION OF ITEMS BEING REQUESTED	CALORIES PER DAY	UNITS PER DAY	# OF MONTHLY REFILLS	LENGTH OF NEED (CANNOT EXCEED 12 MONTHS)

HOW IS TREATMENT PROVIDED?

☐ Mouth (oral) only ☐ Nasogastric (NG-tube) ☐ Gastric (G-tube) ☐ Jejunal (J-tube)

IS THIS THE SOLE SOURCE OF NUTRITION? ☐ Yes ☐ No

WEIGHT LOSS THAT PRESENTS ACTUAL OR POTENTIAL FOR DEVELOPING MALNUTRITION IN ADULTS:

- ☐ A permanent non-function or disease of structures that normally permit food to reach or be absorbed from the small bowel, **OR**
- ☐ Involuntary or acute weight loss equal to or greater than 10% of usual body weight over a 3 to 6 month period, **OR**
- ☐ A Body Mass Index (BMI) below 18.5, **OR**
- ☐ A diagnosis of inborn errors of metabolism that require medically necessary formula used for specific metabolic conditions.

PARENTERAL NUTRITION

Beneficiary's Name_____

Diagnosis which supports the need for Parenteral Nutrition_____

Formula Components: Amino Acid _____ (ml/day) _____concentration % _____ gms protein/day Dextrose _____ (ml/day)_____ concentration% Lipids _____(ml/day)_____ days/week_____ concentration %	Duration of need _____ (1 – 12 months) Number of days per week to be administered _____ (1 – 7)

What is the route of administration?

☐ Central Line (Including PICC) ☐ Hemodialysis Access Line ☐ Peritoneal Catheter

Does the patient have 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? ☐ Yes ☐ No

Has enteral nutrition been tried and failed? ☐ Yes ☐ No

Is the beneficiary able to independently administer the feedings? ☐ Yes ☐ No

If no, does beneficiary have a caregiver who has been trained to provide the feedings? ☐ Yes ☐ No

PRESCRIBER SIGNATURE _____ **DATE** ____/____/_____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY PATIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

Proof of medical necessity is valid for 12 months from the date of issue.