



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](http://www.eohhs.ri.gov/portals/0/uploads/documents/pa_form.pdf)
3. DME PROVIDER TO MAIL ORIGINALS TO: OR FAX TO:
GAINWELL TECHNOLOGIES 401-784-3892
PO 2010, WARWICK, RI 02887 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 _____

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