VERIO HEALTHCARE

Fax to: 619-243-7202

Certificate of Medical Necessity – Enteral Nutrition

Member Name: _____ DOB: ____/_____/_____

Address: _____ CIN: _____

City: _____ Ca. Zip: _____ _____

PH: (_____)_____-_____

____Orally (i.e. drinking)

Formula Prescribed: _____

____ milliliters per day/or ____ Calories per day _____ # Of days per week

____ Administration via tube circle one: ◯ Gastrostomy tube ◯ jejunostomy tube ◯ nasogastric tube

G tube size: _____ Extension Sets: _____

Check the method of administration?

____Syringe/Bolus: _____ ml to be infused per feeding tube at times specified: _____

____Gravity ____ milliliters per day/or ____ Calories per day _____ # Of days per week

____Pump: _____ml per hour for ____ hours per day

Formula Prescribed: _____

Diagnosis(s) (ICD-10): _____

Length of need (# of months): _____

Notes: _____

_____

_____ _____/_____/_____

MD Signature Date

MD Name: _____ NPI: _____

Phone #: _____