Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Enteral Therapy

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____

Diagnosis	**Height**	**Weight**

Prognosis	**Estimated Length of Need (Months) 1–99 (99=Lifetime)**

1. Description of functional impairment?
   - ☐ Malabsorption
   - ☐ Nonfunctioning GI tract
   - ☐ Mental incapacity
   - ☐ Swallowing impairment
   - ☐ Intestinal obstruction
   - ☐ Nausea/Vomiting
   - ☐ Hyper metabolic
   - ☐ Aspiration
   - ☐ Impaired consciousness
   - ☐ Other _____

2. Residence ☐ Home ☐ Nursing Home ☐ Hospital Rehab Unit ☐ Institution ☐ Group Home ☐ Other_____

3. 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

4. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health? ☐ Yes ☐ No

5. How many days per week administered? (1–7) _____

6. List product names with the number of calories per day for each product.

7. Method of administration ☐ Syringe ☐ Gravity ☐ Pump ☐ Does not apply

8. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? ☐ Yes ☐ No

9. Narrative description of **all** items, accessories, options, and special additives ordered to include changes and amounts. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).
   ☐ **Yes**, additional attachments **are** included. ☐ **No**, additional attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Signature and date stamps are not acceptable.

_____ _____

Physician's Signature **Date (mm/dd/yyyy)**