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CHAD WOJNAR R.PH., PRESIDENT **JACK LOVELAND R. PH., VICE PRESIDENT**

Physician's Order Form for Enteral Nutrition

Date Ordered: _____/_____/_____ **Start Date: ____/____/_____**

Patient's Name: _____ **DOB: _____/_____/_____**

Patient's Address: _____

Insurance ID #: _____

Height: _____'_____" **Weight: _____lbs**

**** The physician must complete this information in order to comply with Medicare Guidelines ****

ICD- 10 Code(s): _____ **Length of Need: _____**

Enteral Nutrition Product Name:_____

Directions for

Use:_____

_____

Method of Use: ☐ Pump & IV Pole ☐ Gravity ☐ Syringe

With: Pump fed supply kit (B4035) Gravity fed supply kit (B4036) Syringe fed supply kit (B4034)

Physician Name:_____ **NPI # _____**

Physician's Address:_____

_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____Date ____/____/_____

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