U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 10.02B

ENTERAL NUTRITION

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____
	PT DOB ___/___/___; Sex ___ (M/F); HT.____(in.); WT.____(lbs.) PHYSICIAN NAME, ADDRESS (Printed or Typed) PHYSICIAN'S UPIN: _____ PHYSICIAN'S TELEPHONE #: (___)___-____

SECTION B Information In this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 7, 8, AND 10 - 15 FOR ENTERAL NUTRITION (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
	Questions 1 - 6, and 9, reserved for other or future use.
Y N	7. 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?
Y N	8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status?
A) _____ B) _____	10. Print product name(s).
A) _____ B) _____	11. Calories per day for each product?
_____	12. Days per week administered? (Enter 1 - 7)
1 2 3 4	13. Circle the number for method of administration? 1 - Syringe 2 - Gravity 3 - Pump 4 - Does not apply
Y N D	14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?
	15. Additional information when required by policy:

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)