Hart Medical Equipment

Enteral Feeding Rx

Please fax to: (248) 353-4260
Questions call: (888) 606-8778

❑ New Order
Order Date: _____ ❑ Reorder Length of Need: _____ *(1-99 months)*

For office use only
Account #: _____
Document Type: Physician Order

Patient Name: _____ D.O.B.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Sex: ❑ M ❑ F Ht: _____ Wt: _____ Insurance #: _____

Medical Necessity

Note: *Answers must be supported by information in the patient's medical record.*

As a general rule, for enteral nutrition to be covered by insurance, patient must have either a permanent (lasting at least 3 months) non-function or disease of the structures that normally permit food to reach the small intestine or a disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status. Coverage is possible for patients with partial impairments. If ordering pump, medical records must demonstrate why gravity / bolus failed for this patient.

Primary Dx (ICD-10 Code): _____ Secondary Dx (ICD-10 Code(s)): _____ _____ _____

Method of delivery: ❑ Bolus ❑ Gravity ❑ Pump ❑ Oral (only covered for Medicaid patients)

Feeding tube: ❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy

Number of calories per day: _____ Number of days per week enteral is needed: _____

Administration Rate: _____

Hart Formulary

Formula

❑ Boost (240 calories per can)
❑ Boost Plus (360 calories per can)
❑ Glytrol (250 calories per can) -- *patient must be diabetic*
❑ Diabetisource (300 calories per can) -- *patient must be diabetic*
❑ Isosource HN (300 calories per can)
❑ Isosource 1.5 (375 calories per can)
❑ Other: _____

❑ Nutren 2.0 (500 calories per can)
❑ Nutren 1.0 Fiber (250 calories per can)
❑ Fibersource HN (300 calories per can)
❑ Nutren 1.0 (250 calories per can)
❑ Nutren 1.5 (375 calories per can)

**Additional documentation may be needed to justify the medical necessity*

Bolus Supplies: ❑ Syringes ❑ Split gauze ❑ Tape

Gravity Supplies: ❑ Syringes ❑ Gravity bags ❑ IV Pole ❑ Split gauze ❑ Tape

Pump Supplies: ❑ Infinity Pump ❑ Joey Pump ❑ Syringes ❑ Split gauze ❑ Tape

❑ IV Pole Pump bags: ❑ Feed and flush (Joey Pump Only) ❑ Standard

If ordering a pump, why is bolus / gravity unacceptable for this patient? (check all that apply)

❑ Nausea ❑ Reflux/Aspiration ❑ Diarrhea
❑ Dumping Syndrome ❑ Abdominal Distention ❑ Circulatory Overload
❑ Blood Glucose Fluctuations ❑ Administration rate less than 100 mL/hour

Additional Supplies Needed

Item(s)	Frequency of use (# per day/week/month)	Quantity Ordered (per month)
_____	_____ per _____	_____
_____	_____ per _____	_____

Physician Name: _____ NPI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____
(No signature / date stamps)

Hart Medical offers specialty product options. For more information please call customer service at (888) 606-8778.

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