Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: ENTERAL AND PARENTERAL NUTRITION

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	
	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

This individual receives standard infant formula through a program other than Medicaid (e.g., WIC). ○ Yes ○ No
Product: ____________________ Amount and frequency: ____________________

Product or Item [This section may be completed by the provider.]

Enter all relevant information.

HCPCS code	Description	Calories per can	Cans per case	Calories per day	Units per day

Delivery method: ○ Oral feeding ○ Tube feeding — ☐ Pump ☐ Gravity ☐ Bolus/syringe ☐ Other ____________
Related supply item — ☐ Farrell valve bag/system ☐ Extension set ☐ Lipase cartridge ☐ Other ____________

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

☐ This individual is able to ingest food but cannot derive sufficient energy and nutrients from ordinary food, even if the food is prepared in a liquefied, puréed, or blended form.

☐ The individual is unable to ingest food safely but can digest it.

☐ The individual is unable to digest food in the alimentary canal and must obtain nutrition parenterally.

☐ This individual has difficulty in maintaining weight. Weight history:

Date ___/___/______ Weight ________ Height ________ Date ___/___/______ Weight ________ Height ________
Date ___/___/______ Weight ________ Height ________ Date ___/___/______ Weight ________ Height ________
Date ___/___/______ Weight ________ Height ________ Date ___/___/______ Weight ________ Height ________

☐ This individual requires a daily intake of more than 2,000 calories.
Explanation: ____
____

Diagnosis code(s)	Estimated length of need (≤ 12 months)

☐ Attached are laboratory test results that document nutritional deficiency.

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.

Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.