AHM000056

Enteral Certificate of Medical Necessity

AtHome Medical
200 American Road • Morris Plains, NJ 07950 • 973-538-0485 • Fax: 973-538-2703

Patient Name: _____ DOB _____ Sex _____ Ht _____ Wt _____

Address: _____ SSN: _____

_____ Emergency Contact: _____

Home Phone: _____ Emergency Contact Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

ID No: _____ ID No. _____

Insured: _____ DOB _____ Insured: _____ DOB _____

Does the patient have a permanent non-function of structures that normally permit food to reach or be absorbed by the small bowel? ☐ Yes ☐ No

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

Diagnosis: _____

Length of Need: _____ Formula: _____

(Note: If formula falls in category B4153 or B4154 medical necessity is required to substantiate the higher reimbursement. Examples of possible documentation would include lab test, dietician reports, etc...)

Method of Administration: ❑ Bolus ❑ Gravity ❑ Pump*

*If pump, justification is needed if this patient cannot be fed by bolus/gravity

Justification : _____

Flow Rate: _____ Duration: _____ Days per week: _____

Administer via: ❑ NG ❑ J ❑ G Calories per day: _____ Cans per day: _____

If swallowing test performed please include a copy

Physician _____ NPI _____ Lic _____

Signature_____ Date _____