



STATE OF RHODE ISLAND  
 EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES  
 MEDICAID PROGRAM

**CERTIFICATE OF MEDICAL NECESSITY for ENTERAL NUTRITION**

**Instructions:**

1. DME PROVIDER IS RESPONSIBLE FOR SUBMISSION OF COMPLETED FORM
2. DME PROVIDER TO ATTACH RI MEDICAL ASSISTANCE PA FORM  
[HTTP://WWW.EOHHS.RI.GOV/PORTALS/0/UPLOADS/DOCUMENTS/PA\\_FORM.PDF](http://www.eohhs.ri.gov/portals/0/uploads/documents/pa_form.pdf)
3. DME PROVIDER TO MAIL ORIGINALS TO:  
 HP ENTERPRISE SERVICES  
 PO 2010, WARWICK, RI 02887

**SECTION A: TO BE COMPLETED BY DME PROVIDER . PLEASE PRINT INFORMATION.**

BENEFICIARY'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MEDICAL ASSISTANCE ID NUMBER: \_\_\_\_\_

DME PROVIDER NAME: \_\_\_\_\_

DME PROVIDER CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

HCPCS CODE: \_\_\_\_\_

**PRINT** ORDERING PRESCRIBER'S NAME: \_\_\_\_\_ NPI \_\_\_\_\_

**SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER. PLEASE ATTACH ANY SUPPORTING MEDICAL DOCUMENTATION AS NECESSARY.**

BENEFICIARY'S NAME: \_\_\_\_\_ BMI: \_\_\_\_\_

PRESCRIBER NAME: \_\_\_\_\_

CONTACT NAME (IF DIFFERENT): \_\_\_\_\_ PHONE: \_\_\_\_\_

DESCRIPTION OF ITEMS BEING REQUESTED	CALORIES PER DAY	UNITS PER DAY	# OF MONTHLY REFILLS	LENGTH OF NEED

**Determination of medical necessity for enteral products shall be based upon a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the product, including but not limited to the information below.**

**HOW IS TREATMENT PROVIDED?**

Mouth (oral) only    Nasogastric (NG-tube)    Gastric (G-tube)    Jejunal (J-tube)

**IS THIS THE SOLE SOURCE OF NUTRITION?**    Yes    No

**WEIGHT LOSS THAT PRESENTS ACTUAL OR POTENTIAL FOR DEVELOPING MALNUTRITION:**

**ADULTS:**

Involuntary or acute weight loss equal to or greater than 10% of usual body weight over a 3 to 6 month period, **OR**

A Body Mass Index (BMI) below 18.5, **OR**

A diagnosis of inborn errors of metabolism that require medically necessary formula used for specific metabolic conditions.

**DIAGNOSIS CODE** - Please provide the appropriate Diagnosis Code(s)

**PRESCRIBER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY PATIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.**

**ADDITIONAL PRESCRIBER COMMENTS:**