Add your Logo

ENTERAL NUTRITION WRITTEN CONFIRMATION OF VERBAL ORDER/SWO

Date of Order: _____ Therapy Start Date: _____

PHONE: _____
FAX: _____

Patient ID: _____
Name: _____
Phone:_____ DOB: _____
HT: _____ WT: _____
MBI # _____

Treating Practitioner Info: _____
Name: _____
Phone:_____
Treating Practitioner NPI # _____

DIAGNOSIS INFORMATION

Primary Diagnoses: _____
Secondary Diagnoses: _____

Length of need: _____ **Months**

Test of permanence, greater than 3 months.

Method of Administration: ☐ **Syringe** ☐ **Gravity** ☐ **Pump** ☐ **Oral** **# of Refills:** _____

Enteral

Formula 1: _____ Rate(Bolus/Gravity): _____ Quantity: _____ per/**month**

Formula 2: _____ Rate(Bolus/Gravity): _____ Quantity: _____ per/**month**

Calories per day: _____ *20-35 Kcal/day* Days per week: _____

Flushing Protocol:_____

Additional Information: _____

Syringe Feeding Kits

☐ B4034 – _____Qty Per Month

Pump Feeding Kits

☐ B4035 – _____Qty Per Month, use 1 supply kit a day

Gravity Feeding Kits

☐ B4036 – _____Quantity Per Month

Enteral Feeding Kits

☐ B9002 – QTY 1 - Required due to _____

☐ E0776 – Invacare Standard IV Stand – QTY 1

Other Supplies

☐ G-tube low profile (Button B4088): _____Fr _____cm

☐ J-tube low profile (Button B4088): _____Fr _____cm

☐ B4081 Nasogastric Tubing with Stylet

☐ B4082 Nasogastric Tubing without Stylet

☐ B4083 Stomach Tube-Levine Type

☐ B4087 Gastrostomy/Jejunostomy Tube, Standard, Any Material, Any Type, Each

☐ B4088 Gastrostomy/Jejunostomy Tube, Low-Profile, Any Material, Any Type, Each

Statement of Medical Necessity: Enteral nutrition is required to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.

By signing below I assert I am the treating practitioner for this patient and this patient meets all of the criteria to qualify for Medicare Coverage for this item. Additionally, I understand:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity)must be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Verbal Order Completed By: _____ **Signature:** _____ **Date:**_____

**** Corroborating medical records attached**** Treating Practitioner **Signature:** _____ **Date:**_____