

FAX TO : 1-800-459-2135

Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

ENTERAL NUTRITION PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

NPI #: _____

Prescribing Physician: _____ Medicaid ID # _____

City _____ State _____ Phone #: _____

FAX #: _____

Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

City _____ State _____ Phone #: _____

FAX #: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____ Quantity /Month _____

Daily dose: _____ Length of Therapy _____

Diagnosis: _____ NDC # _____

Consultation with a Registered Dietician? YES NO Date: _____ Name: _____

******Must attach a copy of the original prescription ******

Attach lab results and other documentation as necessary

Indicate Method of Administration: _____ Is nutritional requested the sole source of nutrition? YES NO

Oral (by mouth) _____ Is beneficiary \geq 21 years of age? YES NO

Bolus or Syringe _____ Is beneficiary Medicare eligible? YES NO

TPN (total parental nutrition) _____

Is beneficiary WIC eligible? YES NO If YES, indicate the monthly quantity supplied by WIC: _____

Children under 5 years of age, pregnant and postpartum women must register with the federal program for women, infants, and children (WIC). If WIC cannot supply all of the beneficiary's needs, Medicaid may authorize additional products. A copy of the completed WIC statement must be attached to this form.

FOR HID USE ONLY

Eligibility Verified by _____
Approved _____ Denied/_____
Code: _____
From Date _____ Thru Date _____
Reviewed by _____
HID# _____ PA# _____