Select One:
□ Initial Certification (3 months)
□ First Recertification (6 months)
□ Yearly Recertification (12 months)

Oral Enteral Nutrition Request Form - New Jersey Medicaid

Fax to WellCare Pharmacy Department – Medical Authorizations at: 1-888-340-9512

PHYSICIAN MUST COMPLETE THIS FORM – REQUIRED INFORMATION

Children under 5 Years, pregnant and postpartum women must FIRST register with the federal program for Women, Infants and Children (WIC). A copy of the WIC statement MUST be attached to this form.

Member ID# _____ DOB _____/_____/_____

First name _____ M.I. _____ Last Name _____

Prescriber Name _____ Specialty _____

Contact Person _____ Presciber Phone (_____)_____Prescriber Fax (_____)_____

Food supplement requested:_____

QTY_____ Cans/Scoops/Pkts per Day Length of Therapy _____

Diagnosis _____ ICD-9 _____

Dosage and Frequency of dosing _____ Daily Caloric intake requirement_____

Route of Administration: ❑ Oral Requests Only

Height and Weight (required) _____ft_____in _____ lbs Date measured _____/_____/_____

Comments _____
_____

Is this formula the only form of nutritional intake for this member? ❑ Yes ❑ No
Is this formula necessary in order to prevent mental retardation? ❑ Yes ❑ No
Is the formula necessary in order to sustain life? ❑ Yes ❑ No

Consultation with a Registered Dietician? ❑ Yes ❑ No Date _____ RD Name _____

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* * * **Required Physician Certification Statement** * * *

"I hereby certify that, without this food supplement, this patient will require institutionalization."

Signature _____ Date _____

Please attach a copy of the original prescription. Attach lab results and other documentation as necessary.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.