Oral Nutrition Product Request Form

Prescriber: For medically necessary oral nutrition products, submit this form to the DME provider with a Certificate of Medical Necessity/Prior Approval (CMN/PA) and any supporting documentation (for example, a growth chart or a nutrition assessment).

See Section 5.3.22 of Clinical Coverage Policy 5A, *Durable Medical Equipment*, for more details.

Recipient Information					
Recipient name			Date of birth		
Medicaid ID #					
Is the recipient eligible for WIC?	Y	N	If yes, list the oral nutrition products supplied by WIC:		
Product Information					
Oral nutrition product requested					
Amount of product needed per month					
Expected duration of oral nutrition product					
Medical Diagnosis(es) (list all that are relevant to this request)					
Supporting Data					
Current height/length		Percentile (children)		BMI	
Current weight		Percentile (children)			
Does the recipient have a history of growth failure or weight loss?		Y	N	(If Yes, provide copy of growth chart or weight history.)	
Are there laboratory data indicating nutrition depletion? If Yes, please list.					
Have other nutrition interventions been attempted? If Yes, please list.					
Provider Contact Information					
Name		Telephone			
Parent/Guardian or Recipient Contact Information					
Name		Telephone			