Equipment Request Form

Phone: 586-778-2500
Fax: 866-565-5190

Enteral Nutrition

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**. Please answer all questions below and return to Renaissance Medical. In addition, please make sure a signed copy is kept in your patient's file.

Patient Full Name: _____ Date of Birth: _____

Address City/St/Zip: _____

Medicare # _____ Other Ins Type & # _____

Referring Facility/Name: _____ Contact Name: _____

Requested Delivery Date: _____ Approx Time_____ Length of Need (Months) (99=Lifetime): _____

Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are appropriate for the majority of beneficiaries requiring enteral nutrition.

Enteral nutrition may be administered by syringe, gravity, or pump. Some enteral beneficiaries may experience complications associated with syringe or gravity method of administration.

If a pump (B9000-B9002) is ordered, there must be documentation in the beneficiary's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding).

The feeding supply allowance (B4034-B4036) must correspond to the method of administration indicated in question 5 of the DME Information Form (DIF). If it does not correspond, it will be denied as not reasonable and necessary.

If a pump supply allowance (B4035) is provided and if the medical necessity of the pump is not documented, it will be denied as not reasonable and necessary.

More than three nasogastric tubes (B4081-B4083), or one gastrostomy/jejunostomy tube (B4087-B4088) every three months is not reasonable and necessary.

Type of Nutrition: (Ex: Ensure, Jevity, Isosource, etc.) _____

Delivery Method: ☐ Bolus ☐ Gravity ☐ Pump ☐ Feeding Bags IV Pole: ◯ Yes ◯ No

Number Hours/Day: _____ Calories/Day: _____ If Pump: CC/ML per Hour: _____

Special Instructions: _____

_____

Diagnosis(es) that qualify the need of item delivered: _____

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____

Ordering Physician, PA, or Nurse Practitioner Signature:_____ Date: _____/_____/_____

NPI: _____

Please Fax This Page with Patient Demographics To: 1▪866▪565▪5190