Please complete this form and fax along with Prior-Authorization form to 1-800-953-8856.

maryland physicians care
Medicaid with a Heart

PRESECRIBER STATEMENT OF MEDICAL NECESSITY
NUTRITIONAL SUPPLMENT PRE-AUTHORIZATION FORM
Incomplete forms may result in delay of decision or denial of service.
**This form is not required for metabolic inborn error diseases. **

1. Patient Name:

   Patient Medicaid ID#: DOB:

   Patient Location: ☐ Home ☐ Hospital ☐ Skilled Facility ☐ Other:

   Date of last Doctor's Visit:

   Body Weight: kg *or* lbs Height: ft in Date Measured:

2. Justification for nutritional supplement need

   a) Diagnosis/ICD-10: Date of onset:

   b) Is the patient currently tube-fed? ☐ Yes ☐ No

      If tube-fed, what %: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ < 25%

      Anticipated duration of tube-feeding: # of ☐ Days ☐ Weeks ☐ Months ☐ Indefinitely

      Type / Place tube inserted: Date inserted:

3. RX Nutritional Supplement Order:

Product Name:		
a. Total calories required per day:		# of calories per each unit:
b. # of units per day	x 30 days =	(Total monthly billed units)

4. Prescribers Signature (not required if order attached to request):

   Prescribers Name: NPI:

   Address:

   Phone: Fax: Date Order Written:

5. Name of Pharmacy or Supplier: NPI:

   Address:

   Phone: Fax: