

Fax to: 619-243-7202

## Certificate of Medical Necessity – Enteral Nutrition

Member Name:	DOB:/
Address:	CIN:
City: <u>Ca.</u> Zip:	
PH: ()	
Orally (i.e. drinking)	
Formula Prescribed:	
milliliters per day/or Calories per day	# Of days per week
Administration via tube circle one: Gastrostomy tube	•••
	):
Check the method of administration?	
Syringe/Bolus: ml to be infused per feedGravity milliliters per day/or CaloriesPump:ml per hour for hours per	s per day # Of days per week
Formula Prescribed:	
Diagnosis(s) (ICD-10):	
Length of need (# of months):	
Notes:	
MD Signature	
MD Signature	