Detailed Written Order - Enteral Formula Prescription

SECTION 1:   PATIENT

Patient's Name: _____   Guardian's Name: _____

DOB: _____   Height: _____

Phone: _____   Weight: _____

Address: _____   Allergies: _____

SECTION 2:   DIAGNOSIS

ICD 10 Code: _____

Name of Disorder: _____   (circle answer below)

Is this a metabolic disorder, inborn error of metabolism?   YES   NO

Is there a non-function or disease of the small bowel which impairs absorption of nutrients?   YES   NO

Is Enteral formula the sole source of nutritional intake?   YES   NO

Is Enteral formula required to maintain weight, strength and overall health?   YES   NO

SECTION 3:   FORMULA & PRESCRIPTION

Name of Formula: _____   Place of Service ☐home, ☐other: _____

HCPCS Code: _____   Usage (oral, enteral, etc.): _____

Reimbursement Code: _____   Prescribed Qty/ Day: _____

Formula packaging: _____   Prescribed Qty/ 30 Days: _____

Date order to take effect: _____   Calories/Day: _____

Length of need/months (99 months equals lifetime): _____   Percent daily caloric intake provided by formula: ____

SECTION 4:   ROUTE & ADMINISTRATION

○ Oral   ○ Pump

○ NG tube   ○ Bolus via syringe

○ G-tube   ○ Gravity via bag

○ J-tube   ○ Other: _____

SECTION 5:   PRESCRIBER (MD or DO)

Prescriber's Name: _____   Signature: _____

Prescriber's Clinic: _____   Prescriber's Address: _____

NPI Number: _____   Prescriber's Tax ID: _____

Date: _____

I certify that I am a licensed physician/practitioner under CMS guidelines and qualified to prescribe medical equipment and supplies. I have reviewed the Detailed Written Order and certify that the medical necessity information is true and complete, to the best of my knowledge. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product(s) listed. Additional physician notes and other supporting documentation will be provided upon request. I understand any falsification, omission or concealment of material fact may subject me to liability. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on
the proper use of the prescribed product(s). A copy of this order will be retained as part of the patient's medical record.

Updated 01/2025