

**Certificate of Medical Necessity (CMN) for Enteral Nutrition**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Requesting Provider: \_\_\_\_\_

Pt. Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

1. What diagnosis/condition does the patient have to warrant the use of Enteral Nutrition?

2. Does the patient have permanent non-function or disease of the structures that normally permit food to **reach** or be **absorbed** from the small bowels? Y N D

3. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patients overall health status? Y N D

If yes, what % of calories to be provided by enteral formula? \_\_\_\_\_%

Please specify product name(s): 1) \_\_\_\_\_

2) \_\_\_\_\_

4. Calories per day for each product: 1) \_\_\_\_\_

2) \_\_\_\_\_

5. Days per week administered: \_\_\_\_

6. Circle the number for method of administration:

1 = Syringe      2 = Gravity      3 = Pump      4 = Does not apply

7. Does the patient have a documented allergy or intolerance to any semi-synthetic nutrients? Y N D

8. If special formulation required, provide specific details supporting medical necessity.

Contact Name: \_\_\_\_\_ Phone : \_\_\_\_\_

\_\_\_\_\_  
Physician Signature (Stamps are not acceptable)

\_\_\_\_\_  
Date

Key - (Y)es, (N)o, (D)oes not apply

**Requested Information:**

1. Typed office note with pertinent information.