Letter of Medical Necessity

On (date) _____ (Patient Name)_____

received educational instruction given by (Dietician Name, RD) _____

regarding the recommended renal diet and the need for increased protein intake. Diet modifications proved to be insufficient to meet adequate protein intake, as patient continues below Albumin level of 4.0. Therefore, patient _____ requires nutritional supplements, to be taken orally, to achieve and maintain a healthy albumin level.

I certify that the ordered enteral therapies are medically necessary for my patient

_____ in order to:

_____ Achieve an adequate albumin level the diagnosis of ESRD (N18.6)

_____ Maintain an adequate albumin level with the diagnosis of ESRD (N18.6)

And that stopping/denying enteral therapies could result in malnutrition or have negative health outcomes for this patient.

Additional Comments:

_____
_____
_____

Practitioners Name (PLEASE PRINT): _____

Practitioners Signature: _____

Practitioners Sign Date: _____