847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Oral Nutritional Supplements Order Form

Referral Source:_____ Referral Source Phone:(_____)_____

[ ] Initial order [ ] Renewal order [ ] Product change

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____ Weight loss;_____lbs. since ____/____/_____ BMI;_____

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

Albumin Level;_____

Dialysis Days [ ] mon/wed/fri

[ ] tue/thu/sat

Ship to: [ ] Home [ ] Dialysis Center

What is the essential need over traditional dietary measures to increase calorie/nutrition.

Comments:_____

_____

_____

_____

INSURANCE INFORMATION

Medicare Number:___ NOT COVERED_____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy:_____

PRODUCT(S) REQUESTED

ITEM:_____ Can(s):____a day. Length of Need:_____months Start Date:_____/_____/_____

ITEM:_____ Can(s):____a day. Length of Need:_____months Start Date:_____/_____/_____

ITEM:_____ Can(s):____a day. Length of Need:_____months Start Date:_____/_____/_____

PHYICIAN INFORMATION

Print Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____