



Select One:
 Initial Certification (3 months)
 First Recertification (6 months)
 Yearly Recertification (12 months)

Enteral Nutrition Request Form – Hawai'i Medicaid

Fax to: Toll Free 1-888-877-8239

Children Under 5 Years, Pregnant and Postpartum Women Must FIRST Register with the Federal Program for Women, Infants and Children (WIC). A Copy of the WIC Statement MUST be attached to this Form.

PHYSICIAN COMPLETE THIS SECTION – REQUIRED INFORMATION

Member ID# _____ DOB ____/____/____

First name _____ M.I. _____ Last Name _____

Prescriber Name _____ Specialty _____

Contact Person _____ Prescriber Phone (____) _____ Prescriber Fax (____) _____

Food supplement requested: _____

QTY _____ Cans/Scoops/Pkts per Day _____ Length of Therapy _____

Diagnosis _____ ICD-9 _____

Dosage and Frequency of dosing _____ Daily Caloric intake requirement _____

Route of Administration: Oral G- Tube Feeds NG Tube Jejunostomy Tube Feeds

Height and Weight (required) _____ft _____in _____ lbs Date measured ____/____/____

Comments _____

Is this formula the only form of nutritional intake for this member? Yes No

Is this formula necessary in order to prevent mental retardation? Yes No

Is the formula necessary in order to sustain life? Yes No

Consultation with a Registered Dietician? Yes No Date _____ RD Name _____

*** Required **Physician Certification Statement** ***

"I hereby certify that, without this food supplement, this patient will require institutionalization."

Signature _____ Date _____

Please attach a copy of the original prescription. Attach lab results and other documentation as necessary.

For Internal Use Only

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

FAX to: 'Ohana Health Plan Pharmacy 1-888-877-8239

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.