



820 Mililani Street, Suite 200  
Honolulu, Hawaii 96813

# Oral Nutrition Request Form – Hawai'i

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

Select One:  Initial Certification (three months)  
 Recertification (six months)

Children under 5 years, and 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.

Oral supplements are **not** recommended if BMI  $\geq$  30.

### PHYSICIAN COMPLETE THIS SECTION – REQUIRED INFORMATION

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ DOB: \_\_\_\_\_

Member Address : \_\_\_\_\_ Member Phone: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Requesting Agency: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Vendor/Supplier: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Food Supplement Requested **and** Quantity: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_ Daily Caloric Intake Requirement: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight: \_\_\_\_\_ Lbs. Date Measured: \_\_\_\_\_

Member lives alone; has limited ability to shop, cook or feed self.

CLINICAL COVERAGE CRITERIA	Y/N	NOTES
1. There has been unintentional weight loss: • 5% or more in the past month, or • 10% or more over past six months	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
2. Body Mass Index (BMI) is less than 20 BMI = (wt in kg) divided by ([ht in meters x ht in meters])	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. Albumin less than 3.4 gm/dL	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Patient has poorly healing wounds or pressure ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Patient has teeth, mouth or swallowing problems that limit intake of foods	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Unsuccessful attempts to increase calorie intake using food and beverages (2–3 snacks per day, milk shakes, smoothies, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is this formula the only form of nutritional intake for this patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional information supporting patient’s need for nutritional supplement:		

**\*\*\* 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.*

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