

Enteral Nutrition

Create a new Authorization or edit Member information (see [Getting Started](#)).

Note: All fields with a red asterisk are required.

Select Enteral Nutrition Service from the *Authorization Type* dropdown menu and fill out *Submitter Information* in full.

Create Authorization

Member

PMI #	Last Name	First Name	Date of Birth	Soc Sec #
99999001	Primewest	Mary	07/01/1954	

New Search

Authorization Type*

Enteral Nutrition Service

Submitter Information

First Name*

provider5

Last Name*

Basic

Phone:*

() - -

Ext:

Email*

provider5@test.com

Start Date*

MM/DD/YYYY

End Date*

MM/DD/YYYY

Select Oral or Tube feeding from the *Administration Route* dropdown menu. If you select Tube feeding, no authorization is required.

Fill out fields as needed. You must select a facility under *Pharmacy or DME Provider*.

Administration Route*		
Oral ▼		
Does member live in nursing home?*		
▼		
Nutritional Product*		HCPCS code*
▼		▼
Calories per can*	Units per can*	Product Type*
▼	▼	▼
Pharmacy or DME provider		
Select Facility		
This field is required		
Phone*		
() -		
Request Type*		
▼		
Date last seen by physician*		
mm/dd/yyyy		

Continue filling out required fields with information necessary for the request.

Note: You must indicate if this is an *expedited request*. An expedited request is appropriate when the standard time frame for determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

When the form is complete, attach supporting documentation and click *Submit*.

Diagnosis

Primary ICD 10 Code*

Diagnosis Description

Add Diagnosis

Describe how diagnosis is related to the need for enteral nutrition therapy

description

Total calories needed per day*

Total calories from other ingested foods and liquids*

Total calories from enteral products*

Height*

Weight*

Target weight*

Other therapy/treatment that may justify the need for the enteral nutrition product

description

Is this an expedited request?*

This field is required

Attachments

Physician order must be included.
Supporting documentation (History of present illness, complete admission orders, lab results, emergency department records and other.)

File

Choose File

No file chosen

Submit

Cancel

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