Fax form to **612-223-8661** to order **enteral nutritional supplements** for your patient.

Physician's Written Order
Enteral Nutrition

INSIGHT MEDICAL

PATIENT INFO

First | MI | Last

DOB | Gender

Street | City | State | Zip

Phone | Email

Caregiver Contact | Phone | Email | Relationship

INSURANCE

Primary Insurance Policy Holder Name | DOB | Secondary Insurance Policy Holder Name | DOB

Primary Insurance | Phone | Secondary Insurance | Phone

Policy/ID | Group # | Policy/ID | Group #

PRESCRIBING PHYSICIAN

First | MI | Last

Street | City | State | Zip

Phone | Fax | NPI#

DIAGNOSIS

Start Date: ____ /____ /_____ **Estimated Length of Need:** _____ months *(99 = lifetime)*

Height: _____ **Weight:** _____ **ICD-10 Diagnosis Code:** _____

1. If enteral nutrition is being routed for administration via tube, please indicate the route:
   ☐ **Gastrostomy Tube** ☐ **Jejunostomy Tube** ☐ **Nasogastric Tube** ☐ **Other**
2. **Prescribed calories per day:** _____ or _____ *(ounces/day)*
3. Method of administration of the enteral nutrition is:
   ☐ **Syringe** ☐ **Pump** ☐ **Gravity** ☐ **Oral**
4. Formula type/s used to fill order:
   - ☐ Kate Farms® **Pediatric Peptide 1.5** *Vanilla* **(B4161)**
   - ☐ PediaSure® *Pediatric Oral Supplement 1.5 Cal* **(B4160)**
   - ☐ Nestle ISOSOURCE 1.5 Cal w/ Fiber **(B4152)**
   - ☐ Nestle® *Pediatric Tube Feeding Formula Compleat* **(B4153)**
   - ☐ Boost® *Oral Supplement* **(B4150)**
   - ☐ Jevity Supplement w/ Fiber (B4152)

   Other (Specify): _____
5. **Quantity to Dispense:** _____ **Frequency of Use:** _____
   Quantities will be provided in daily and/or only unit increments, where 1 unit = 100 calories

1. **TOTAL CALORIES NEEDED PER DAY** _____
2. **TOTAL CALORIES FROM OTHER INGESTED FOODS AND LIQUIDS** _____
3. **TOTAL CALORIES FROM ENTERAL PRODUCTS** _____

Medical records may be required for insurance coverage

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record supporting documentation that substantiates the utilization and medical necessity of the products listed and physical notes and other supporting documentation will be provided to Insight Medical Supply upon request. I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician/Practitioner Signature: *(Stamps are not acceptable)* Date: _____

Printed Name: