Physician's Written Order

Enteral Nutrition

To request free samples for your patient, please visit **reasonhealth.com.**

PATIENT

First | MI | Last

DOB | Gender | Height | Weight

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 #

Patient's Current Home Medical Supplier

PRESCRIBING PHYSICIAN

First | MI | Last

Street | City | State | Zip

Phone | Fax | NPI#

DIAGNOSIS

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

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. Quantity to Dispense **PER DAY**: _____ ☐ mL ☐ Carton ☐ Calories
3. Please indicate feeding plan (amount and frequency): _____
4. Method of administration of the enteral nutrition is (check all that apply):
   ☐ Syringe ☐ Pump ☐ Gravity ☐ Oral
5. Formula type/s used to fill order: **DISPENSE AS WRITTEN, NO SUBSTITUTIONS.**

   [ ] Reason High Calorie Protein Beverage Vanilla flavor (B4155)
   [ ] Reason High Calorie Protein Beverage Chocolate flavor (B4155)
   [ ] Reason High Calorie Protein Beverage Strawberry flavor (B4155)

Medical records may be required for insurance coverage. Please send this form, insurance cards and appropriate clinical documentation to the medical supply company

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.

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

Printed Name: _____