Enteral Referral Order Form

SEND THE COMPLETED FORM TO:	
Company:	
Attn:	
FAX#:	Email:

PATIENT INFORMATION

First:	Last:	MI:	DOB:	
Address:		City:	State:	Zip:
Home Phone:	Mobile Phone:			
Caregiver Name:	Relationship:		Phone:	

INSURANCE INFORMATION

Primary Insurance			**Secondary Insurance**		
Subscriber Name:		DOB:	Subscriber Name:		DOB:
Member ID:	Group:	Plan:	Member ID:	Group:	Plan:
Insurance Claims Phone:			Insurance Claims Phone:		

PHYSICIAN ORDER (Dispensing Order/Detailed Written Order)

Real Food Blends® - HCPCS B4149 Pouches per day:

- ☐ Chicken, Carrots & Brown Rice (340 Cal)
- ☐ Beef, Potatoes & Spinach (330 Cal)
- ☐ Salmon, Oats & Squash (330 Cal)
- ☐ Turkey, Sweet Potatoes & Peaches (320 Cal)
- ☐ Eggs, Apples & Oats (320 Cal)
- ☐ Quinoa, Kale & Hemp (330 Cal)
- ☐ Prunes, Pears & Pumpkin Mini snack (100 Cal)

Free Water Flushes: Start Date:

If enteral nutrition is being routed for administration via tube, please indicate the route: ☐ Gastrostomy Tube ☐ Other _____

ICD-10 Diagnosis Code:

DISPENSE AS WRITTEN, NO SUBSTITUTIONS

Method of Administration: ☐ Syringe Bolus ☐ Gravity ☐ Pump

Start Date: Estimated length of need: _____ months _____ # Refills

PHYSICIAN INFORMATION

First Name:	MI:	Last:
Street Address:		
City:	State:	Zip:
Physician's Phone Number:	Fax:	
NPI #:	Date:	
Physician/Practitioner Signature:		(stamps are not acceptable)

I certify that I am the physician/practitioner identified on this document and I have reviewed this Enteral Referral Order Form. I attest that any information presented on this form is accurate to the best of my knowledge. I understand that medical records, insurance card, or additional information may be required for insurance coverage. I am authorized to provide the information contained in this form to the recipient, an authorized DME/home infusion supplier, and the patient/caregiver listed on this form is aware that the recipient may be contacting them for additional information to process this order, as needed. I understand that I should not send this form to Nutricia North America. I confirm I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies.

This form is an example template provided as a courtesy to healthcare providers. By making this document available, Nutricia North America is not providing any guarantees regarding this form, insurance coverage, or the suitability of its products for any specific patient. This enteral order form and any attachments may contain confidential information and is intended to be sent directly to a DME/home infusion supplier. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing, or forwarding.

Please send this enteral order form and associated clinical documentation directly to a DME/home infusion supplier.