

# Enteral Referral Order Form

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

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:

<input type="checkbox"/> Select™ Chicken, Zucchini & Potatoes (410 Cal)	<input type="checkbox"/> Select™ Turkey, Pears & Pumpkin (410 Cal)	<input type="checkbox"/> Salmon, Oats & Squash (330 Cal)
<input type="checkbox"/> Turkey, Sweet Potatoes & Peaches (320 Cal)	<input type="checkbox"/> Eggs, Apples & Oats (320 Cal)	<input type="checkbox"/> Quinoa, Kale & Hemp (340 Cal)
<input type="checkbox"/> Chicken, Carrots & Brown Rice (340 Cal)	<input type="checkbox"/> Beef, Potatoes & Spinach (330 Cal)	<input type="checkbox"/> Mini Prunes, Pears & Pumpkin 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.

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