

## Oral Nutrition Product Request Form

Prescriber: For medically necessary oral nutrition products, submit this form to the DME provider with a Certificate of Medical Necessity/Prior Approval (CMN/PA) and any supporting documentation (for example, a growth chart or a nutrition assessment).

See [Section 5.3.22 of Clinical Coverage Policy 5A, Durable Medical Equipment](#), for more details.

<b>Recipient Information</b>				
Recipient name		Date of birth		
Medicaid ID #				
Is the recipient eligible for WIC?	Y	N	If yes, list the oral nutrition products supplied by WIC:	
<b>Product Information</b>				
Oral nutrition product requested				
Amount of product needed per month				
Expected duration of oral nutrition product				
<b>Medical Diagnosis(es) (list all that are relevant to this request)</b>				
<b>Supporting Data</b>				
Current height/length		Percentile (children)		BMI
Current weight		Percentile (children)		
Does the recipient have a history of growth failure or weight loss?	Y	N	(If Yes, provide copy of growth chart or weight history.)	
Are there laboratory data indicating nutrition depletion? If Yes, please list.				
Have other nutrition interventions been attempted? If Yes, please list.				
<b>Provider Contact Information</b>				
Name		Telephone		
<b>Parent/Guardian or Recipient Contact Information</b>				
Name		Telephone		