FORT | Advantage Care
RESPIRATORY AND MEDICAL EQUIPMENT

Enteral WOPD

Written Order Prior to Delivery

Fort Medical Equipment, LLC
306 Washington Street
Ft. Atkinson, WI. 53538-1741
Phone: 920-568-9860
Fax: 872-469-1691

Order Date: _____

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Duration: ☐ Lifetime (99) Other _____ months

Height: _____ Weight: _____

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, and dietitian notes. Documentation must include diagnosis and the need for the enteral supplies. Also, it is required that the date of this form is the same or after the date on the Clinical Notes and Face to Face.

Is the enteral nutrition being provided via feeding tube?	**YES**	**NO**
Does the patient require enteral feedings to maintain weight and strength?	**YES**	**NO**
Will the enteral feedings be required for 3 months or longer?	**YES**	**NO**

Prescribed Enteral Formula

Nutrient: _____ ml/day: _____and/or Calories/day: _____

Additional Enteral Formula

Additional Nutrient: _____ ml/day: _____and/or Calories/day: _____

Route of Administration - Must Select One

☐ **Enteral Feeding Pump Pump Rate : _____ml per hour** (B4035 Pump Kit/E0776 IV Pole/B9002 Feeding Pump/Flush Syringe) - **Must have documentation to justify the need for the pump**. (i.e. gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, rate less than 100ml/hour, blood glucose fluctuation.)

☐ **Enteral Feeding Syringe** (B4034 Supply Kit/Syringes)

☐ **Enteral Feeding Gravity** (B4036 Gravity Supply Kit/ E0776 IV Pole/Flush Syringe)

The following criteria must be met for the above selected item to be covered. (This information has been obtained from the Medicare Policy)

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.