Appendix M

CERTIFICATION FOR ENTERAL NUTRITION *Must be under age 21

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number _____ Date of Birth _____
Member Full Name _____
Select one:
☐ Initial Certification (3 months)
☐ First Recertification (6 months)
☐ Yearly Recertification (12 months)

Diagnosis:_____**ICD-9**_____
What functional impairment of the alimentary tract is present?
_____
Height: _____ Height change since last certification: _____
Weight: _____ Weight change since last certification: _____
Is this formula the only form of nutritional intake for this member? ☐YES* ☐ NO
Is this formula necessary in order to prevent mental retardation? ☐YES* ☐ NO
Is this formula necessary in order to sustain life? ☐YES* ☐ NO
* At least one must be checked yes to qualify.
Administration Information
☐ Oral ☐ G-Tube ☐ NG-Tube ☐ Jejunostomy Tube
If requesting tubes, which kind? _____How many per month?_____ Who changes tubes?_____ If more than 3 per month, why?_____

Formula: _____
Total calories per day: _____
WIC allotment* in calories per day: _____
Difference between total caloric need and WIC allotment: _____
☐ Check if formula is not covered by WIC; if not covered by WIC, send statement from DFAC's verifying it is not covered.

***Note**: *All* children who are under age 5 should have a WIC allotment - vouchers are to be used for formula for those children who need it. Medicaid only reimburses the amount **not** covered by WIC. Check with member's county DFCS office for WIC allotment.

I CERTIFY THAT ENTERAL NUTRITION IS MEDICALLY NECESSARY:

Physician Signature * _____ **Date** _____
Physician's Printed Name_____
Address_____
***Stamped signatures or dates are not acceptable**