

**Combined MassHealth Managed Care Organization (MCO)
 Medical Necessity Review Form
 For Enteral Nutrition Products (Special Formula)**

You must submit this form with your request for prior authorization. The form must be completed by the prescriber and have a copy of the prescription attached. **Please refer to the instructions for completing this form provided at the end of this document.**

Please print or type all sections.

1. Member's name:	2. Member's ID no:
3. Member's DOB (Age): <input type="checkbox"/> Weeks of gestation for premies (if applicable):	4. Member/family's primary language:
5. Member's address and telephone no: Telephone No: _____	6. Member's current location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____ Telephone No: _____
7. Primary diagnosis name and ICD-9-CM code:	8. Secondary diagnosis name and ICD-9-CM code:
9. Anthropometric measures (Complete all items.) <input type="checkbox"/> Height: _____ <input type="checkbox"/> Weight: _____ <input type="checkbox"/> Growth percentile (child only): _____ <input type="checkbox"/> Body mass index (BMI): _____ <input type="checkbox"/> Basal metabolic rate (BMR): _____ <input type="checkbox"/> Ideal body weight: _____	10. Laboratory tests (Attach results) <input type="checkbox"/> Type of blood tests (specify): _____ <input type="checkbox"/> Type of urine tests (specify): _____ <input type="checkbox"/> Allergy testing (specify): _____ <input type="checkbox"/> Other tests (specify): _____
11. Risk factors (Use attachments as needed.) <input type="checkbox"/> Anatomic structure of gastrointestinal tract <input type="checkbox"/> Neurological disorder (specify): _____ <input type="checkbox"/> Inborn errors of metabolism (specify): _____ <input type="checkbox"/> Malabsorption syndrome (specify type): _____ <input type="checkbox"/> Treatment with anti-nutrient or catabolic properties <input type="checkbox"/> Increased metabolic or caloric need <input type="checkbox"/> Other (Specify): _____	12. Route of treatment <input type="checkbox"/> Mouth (oral) only <input type="checkbox"/> Nasogastric (NG-tube) <input type="checkbox"/> Gastric (G-tube) <input type="checkbox"/> Jejunal (J-tube) <input type="checkbox"/> Other (specify): _____
13. Treatment regimen initiated (Attach explanation.) <input type="checkbox"/> Past (Note: specific dates of duration of usage and signs and symptoms of complications of any prior used formulas) <input type="checkbox"/> Current (last six months) <input type="checkbox"/> None	14. Expected treatment outcome (Attach explanation.) <input type="checkbox"/> Expected to improve within 3 months <input type="checkbox"/> Expected to improve within 6 months <input type="checkbox"/> Expected to improve within 12 months <input type="checkbox"/> Not expected to improve
15. Location where member will use items: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____	16. *Expedited service authorization request (Must attach detailed explanation.) Could seriously jeopardize the member's: <input type="checkbox"/> Life or health <input type="checkbox"/> Ability to attain, maintain, or regain maximum function <input type="checkbox"/> Other (Specify): _____ <i>*MCO Plan to provide notice to provider no later than 3 business days after receipt of request.</i>
17. Duration of need (number of months):	18. No. of refills:

19. Enteral formula and supplies	20. Volume/fluid oz. per day	21. Quantity per month	
a.			
b.			
c.			
22. Type of formula requested: <input type="checkbox"/> P = powder <input type="checkbox"/> R = ready-to-use <input type="checkbox"/> C = concentrate			
23. DME provider			
Company name:		NPI provider ID no. (if available):	
Address:		Telephone no. (if available): Fax no. (if available):	
24. Prescriber		25. Person completing form on behalf of prescriber	
Name:		Name:	
Address:		Title:	
Telephone no.:		Telephone no.:	
Fax no.:		Fax no.:	
NPI provider ID no.:		Organization:	

26. Attestation: I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

Prescriber attestation (signature)

Date (mm/dd/yy)

This form must be completed by the prescriber. Please check off the member's MCO Plan and fax this completed and signed form according to the MCO's special instructions below.

<input type="checkbox"/> Boston Medical Center HealthNet Plan (BMCHP) Contact Person/Department: Health Services Department Tel #: 888-566-0008, Option 3 Special Instructions: Chose a BMCHP contracted DME vendor from the attached list and fax the form directly to the DME vendor. This list and the Special Formula/Enteral Nutrition form can also be found at: http://www.bmchp.org/pages/providers/provider_home.aspx (click on Authorization Forms, Enteral Nutrition Request Form)
<input type="checkbox"/> Fallon Community Health Plan (FCHP) Contact Person/Department: Pam Perdue, RN/Care Review Department/Alternate: Ann Marie Rousseau, RN Tel #: 508-368-9021/508-368-9141 Fax #: 508-368-9133 Special Instructions: Please provide notes of past one year of office visits, yearly check ups, testing results and growth charts.
<input type="checkbox"/> Neighborhood Health Plan (NHP) Department: Clinical Services Dept./DME-Nutritional Authorizations Team Tel #: 1-800-462-5449 Fax #: 617-526-1935 Special Instructions: The completed form is to be faxed to the contracted DME/medical supplier. NHP has a list of contracted medical suppliers at our website; www.nhp.org/pages/providers_home.aspx (click Administrative Resources, Forms & Applications, List of Vendors & Suppliers)
<input type="checkbox"/> Network Health (NH) Contact Person/Department: Marie Chiulli, RN Tel #: 888-257-1985 Fax #: 781-393-2601 Special Instructions: For a list of our DME vendors, visit our Web site at www.network-health.org

Note: Prior-authorization requests with incomplete medical necessity documentation may be returned for more information or denied. Please refer to the *MassHealth and MCO Guidelines for Medical Necessity Determination for Enteral Nutrition Products* for further information about submitting required clinical documentation.

Instructions: Complete all applicable fields on the form. Print or type all sections.

Item 1	Member's name	Enter the member's name as it appears on the MCO Plan card.
Item 2	Member's MCO ID no.	Enter the member's MCO Plan identification number, which appears beside the member's name on the MCO card.
Item 3	Member's DOB/Age	Enter the member's date of birth in month/day/year order and age. Also include weeks of gestation for premies if applicable.
Item 4	Member/family's primary language	Enter the member/family's primary language. (If other than English this will flag the possible need for translator and/or interpreter services).
Item 5	Member's address	Enter the member's permanent legal address (street address, town, and zip code) including telephone where can be reached.
Item 6	Member's current location	Place a checkmark beside the member's current location (include telephone number).
Item 7	Primary diagnosis	Enter the primary diagnosis name and ICD-9-CM code that corresponds to the nutritional disorder for which the enteral product is being requested. Include evidence based clinical data regarding disease processes (i.e. not just GERD – all the clinical data that confirms that diagnosis).
Item 8	Secondary diagnosis	Enter the secondary diagnosis name and ICD-9-CM codes (up to three codes) that further describe medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable. Include evidence based clinical data regarding disease processes (i.e. not just GERD – all the clinical data that confirms that diagnosis).
Item 9	Anthropometric measures	Complete all items associated with signs and symptoms of nutritional risk. Enter the member's height in inches, weight in pounds, body mass index, basal metabolic rate, and ideal body weight. Enter the growth percentile for children, and attach a growth chart.
Item 10	Laboratory tests	Place a check mark beside all diagnostic laboratory tests that apply, and specify the type of tests (for example, serum albumin, hematocrit, and enzyme profiles) in the space provided. Attach the results for each test.
Item 11	Risk factors	Place a check mark beside all risk factors that may affect treatment of nutritional risk. When indicated, specify the risk factors in the risk space provided. Attach clinical information for items checked.
Item 12	Route of treatment	Place a check mark beside the primary method that enteral products will be administered. If checking "Other", specify the method (for example, gravity, pump, or syringe) in the space provided.
Item 13	Treatment regimen initiated	Place a checkmark beside treatments that have been tried to manage nutritional risk. Attach an explanation on other nutritional support products used and responsiveness to such treatments.
Item 14	Expected treatment outcome	Place a checkmark beside the item that describes the prognosis for improvement with enteral treatment. Attach an explanation.
Item 15	Location where member will use items	Place a checkmark beside all locations that apply to use of this product. If checking "Other", specify the location where the product will be used (for example, skilled nursing facility or end stage renal disease facility) in the space provided.
Item 16	Expedited service authorization request	Place a checkmark beside the reason for requesting an expedited service authorization request. Must attach a detailed explanation for any reason checked.
Item 17	Duration of need	Enter the total number of months that the prescriber expects the member to require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use.
Item 18	No. of refills	Enter the number of monthly refills for this prescription.
Item 19	Enteral formula and supplies	Print the name of the enteral formula being requested and, if applicable, the supplies (for example, syringes or pump) required to administer the formula.
Item 20	Volume/fluid oz. per day	Enter the volume/fluid oz. per day of reconstituted formula being recommended for the member.
Item 21	Quantity per month	Enter the quantity of enteral products requested per month for items listed (for example, 30 8-oz. cans).
Item 22	Type of formula requested	Place a checkmark beside the type of formula requested.
Item 23	DME provider	Enter the company name and address of the provider who will supply the enteral product(s) being requested. If available, also provide the DME provider's telephone and fax numbers and provider National Provider Identifier (NPI) number.
Item 24	Prescriber	Enter the physician's/clinician's name, address, telephone and fax numbers where he or she can be contacted if more information is needed. Include the prescriber's MCO Plan provider's NPI number, or if the prescriber is not an MCO Plan provider, enter the prescriber's NPI number.
Item 25	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse, dietician, physical therapist, or nursing facility staff) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title, and name of employer (organization) where indicated.
Item 26	Attestation	The prescriber must attest that the clinical information provided on this form is accurate and complete to the best of the prescriber's knowledge by signing this field.