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:

- ☐ Select™ Chicken, Zucchini & Potatoes (410 Cal)
- ☐ Select™ Turkey, Pears & Pumpkin (410 Cal)
- ☐ Salmon, Oats & Squash (330 Cal)
- ☐ Turkey, Sweet Potatoes & Peaches (320 Cal)
- ☐ Eggs, Apples & Oats (320 Cal)
- ☐ Quinoa, Kale & Hemp (340 Cal)
- ☐ Chicken, Carrots & Brown Rice (340 Cal)
- ☐ Beef, Potatoes & Spinach (330 Cal)
- ☐ 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.