Mail request to: ACS PO BOX 7090 Tallahassee, FL 32314-7090 Toll-Free Fax: 1-877-614-1078	**DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY SERVICES** **AUTHORIZATION REQUEST FOR ENTERAL FORMULA**	FLORIDA MEDICAID

PART 1: PHYSICIAN'S CERTIFICATION STATEMENT *(Must be completed by the recipient's physician)*

Recipient ID number (10 digits): Recipient Name: Age: Date of Birth: Qualifying diagnosis: Diagnosis Code (ICD-9):	Name of enteral formula ordered: Total # Calories per day from enteral formula: _____ Formula constitutes _____% of recipients' daily nutrition ☐ Administer by tube ☐ Administer orally	Height: Date measured: BMI: Projected length of therapy (0-6 months):	Weight: Date measured:

Treating physician: _____ License #: _____ Medicaid ID #: _____ NPI#: _____
(Print)

Address: _____ City: _____ State: _____ Zip: _____

Signature of treating physician: _____ Phone Number: ( ) _____-_____ Date: _____

PART 2: WIC PROGRAM *(This statement must be completed by WIC Nutritionist)*
Children under 5 years, pregnant, breastfeeding, and postpartum women must register with the Women, Infants, and Children (WIC) Program.

This is to verify that the Florida WIC Program has provided the maximum amount of the requested enteral formula(s) to the above participant as allowable under Federal Regulations. It is deemed that this is an appropriate enteral formula(s) based on the diagnosis and patient counseling. WIC staff may need to contact the health care provider to obtain more detailed medical information prior to WIC approval of this enteral formula request.

Amount enteral formula(s) per month provided by WIC _____
(If none, nutritionist must state the reason why the WIC program is not providing the formula)

Amount enteral formula(s) per month requested from Medicaid _____

_____ _____ _____
WIC Nutritionist's Signature and Title | Phone Number | Date

PART 3: DME PROVIDER *(Must be completed by the DME Provider)*

DME Provider Name:	DME Provider Number:	Procedure (HCPC) Code:	Provider Contact Name:
DME Provider Address:	How to calculate units: 100 Calories = one unit **Calories:** Total number per day from enteral formula _____ **Units:** Divide number of Calories by 100 _____ **Units per month:** Multiply units by 31 _____ (If Patient is on WIC, approved calculation is based on line 2 of part 2)		Tel. #:( ) _____--_____ Fax #:( ) _____--_____

_____ _____ _____
Provider Signature | *Printed Name* | *Date*

Note: *Prior authorization requests for consumables listed on the DME Fee Schedule without a scheduled fee [B4153, B4155, B4157, B4161, B4162,S9434] require appropriate invoice and catalog documentation with the Prior Authorization Request.*

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☐ Approved Date:	# Total Units: Total Amount: $
☐ Denied Date:	Denial Reason Code #:

Reviewer Comments:

_____

Reviewed By: _____ _____
Signature | Date

Approved authorizations do not guarantee payment, but are contingent upon recipient and provider *Eligibility* on *the Date of Service* and services being provided not more than 120 days from the date of service. Updated 030106

Please allow 3 business days for processing. To check on status after 3 business days, please call 1-800-289-7799

Durable Medical Equipment and Medical Supply Services
Authorization Request for Enteral Formula

INSTRUCTIONS

Note: Prior authorization requests for consumables listed on the DME Fee Schedule without a scheduled fee [B4153, B4155, B4157, B4161, B4162, S9434] require appropriate invoice and catalog documentation with the Prior Authorization Request

Pricing methodology: Manufacturer's wholesale price plus 10%; provider's attainment cost (less mfg. discounts, shipping & handling) plus 10%; or provider's usual and customary, whichever is less.

Please print legibly or type. An interactive version of this form may be accessed online.

Part 1: MUST BE COMPLETED BY THE RECIPIENT'S PHYSICIAN THEN FORWARDED TO EITHER THE DME PROVIDER, WIC PROGRAM, OR TO THE MEDICAID RECIPIENT TO FORWARD.

Recipient Number: Enter ten-digit original Medicaid identification number of the recipient requesting prior authorization for enteral formula.
Recipient Name: Print the Medicaid recipient's first and last name.
Age: Enter the age of recipient.
Date of Birth: Enter the month, day, and year of recipient's birth (mm-dd-yy).
Qualifying Diagnosis: Print recipient's qualifying diagnosis that supports the need for enteral formula.
Diagnosis Code (ICD-9): Enter the appropriate ICD-9 code for the diagnosis listed in the Qualifying Diagnosis box.
Name of Enteral Formula Ordered: Print the brand name of the product ordered.
Formula constitutes: Indicate the percentage of the recipient's daily nutritional intake that the requested enteral formula will represent (1 – 100 %).
Administer by □ tube, □ Administer orally: Indicate the route of administration.
Height, Weight and Dates Measured: Enter the recipient's most recently documented height and weight and the date the measurements were obtained.
BMI: Enter the requesting recipient's most recently calculated body mass index.
Projected length of therapy (0-6 months): Indicate the length of time (not to exceed 6 months) that the recipient will need enteral formula.
Treating Physician: Print the first and last name of the Medicaid recipient's prescriber (i.e., MD, PA, ARNP).
License #: Enter the current Florida license number of the prescriber affixing his signature in Part 1 of this form.
Medicaid ID #: If prescriber is currently enrolled as a Medicaid provider, enter the nine-digit identification number assigned by Medicaid. If the prescriber is not currently enrolled as a Medicaid provider, enter N/A.
NPI #: (National Provider Identification) Enter prescriber's assigned NPI number. If the prescriber has not been assigned a NPI number, enter N/A.
Address, City, State, Zip: Enter the complete business mailing address of prescriber.
Signature of the treating physician: Signature of prescriber.
Phone number: Enter a contact telephone number (including area code) of prescriber.
Date: Enter the current date.
For renal dialysis patients: Attach supporting documentation as stated in the enteral policy.

Part 2: MUST BE COMPLETED BY WIC NUTRITIONIST IF MEDICAID RECIPIENT IS LESS THAN 5 YEARS OF AGE, OR A PREGANT, BREASTFEEDING, OR POSTPARTUM WOMAN.

Amount enteral formula(s) per month provided by WIC: Enter the total amount of formula provided monthly by the WIC program.
Amount enteral formula(s) per month requested from Medicaid: Enter the calculated amount needed to supplement WIC's monthly provision to meet the total Calories per day ordered by the prescriber.
WIC Dietitian/Nutritionist's Signature and Title: signature and title of the WIC nutritionist completing Part 2 of this form
Phone Number: Enter a contact telephone number for the WIC nutritionist completing Part 2 of this form.
Date: Enter the date of the WIC nutritionist signature in Part 2 of this authorization form.

Part 3: THE DME PROVIDER IS RESPONSIBLE FOR SUBMITTING THE COMPLETED AUTHORIZATION REQUEST FORM TO THE APPROPRIATE ADDRESS FOR REVIEW.

DME Provider Name: Print the complete company name of the enrolled Medicaid DME provider submitting this authorization request.
DME Provider Number: Enter the enrolled DME provider's nine-digit Medicaid identification number.
Procedure (HCPCS) Code: Enter appropriate alphanumeric procedure code of the enteral formula requested (example: B4153).
Note: *HCPCS (pronounced "hick-picks") is the acronym for the Healthcare Common Procedure Coding System. The alpha-numeric HCPCS codes (procedure codes) covered by the durable medical equipment and medical supply services program are listed in the current DME fee schedules, posted online at the following web address*: *http://floridamedicaid.acs-inc.com*
DME Provider Address: Print the complete mailing address, including street address, suite number, city and zip code of the enrolled Medicaid DME provider location submitting this authorization request.
How to Calculate units: Enter the maximum number of Calories prescribed per day. Note*: If the physician's order in Part 1 of this form indicates the recipient must receive 2,500 Calories per day, use the following calculation to determine the total # units per month: 2,500 Calories per day divided by 100 = 25 units x 31 maximum days per month = 775 units per month.*
Provider Contact Name, phone #, fax #: Print the first and last name of a contact person, telephone number and fax number (including area code).
Provider Signature: Authorized DME provider signature, per Medicaid agreement.
Printed Name: Print first and last name of the affixed signature in Part 3 of this authorization request.
Date: Enter the date of the DME provider signature in Part 3 of this form (mm-dd-yy).

ACS OFFI CE USE ONLY: This section is only used by the Agency for Health Care Administration staff or the agency's authorized PA reviewers.

Updated 030106