



Written Order Prior to Delivery (WOPD)

Enteral

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4353
Phone: 847-310-4730 *3
Fax: 872-469-1673

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.