MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR ENTERAL NUTRITION PRODUCTS

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Sections 1, 2, 3, and 4 may be completed by the provider of DME or the prescribing provider.
Section 5 must be completed by the provider of DME. Sections 4A (shaded below), 6, and 7 must be filled out by the prescribing provider.

SECTION 1

Member Name			Date of Delivery	
Address			Telephone	
MassHealth ID	Date of Birth	Gender	Height	Weight
Primary ICD Code	Description			
Secondary ICD Code	Description			

SECTION 2

Prescribing Provider's Name	NPI
Address	
Telephone	Fax

SECTION 3

Name of Provider of DME	NPI
Address	
Telephone	Fax

SECTION 4

Place checkmark beside item requested and enter the appropriate HCPCS code and their modifiers and description of equipment.

SECTION 4A

(Must be completed by the member's prescribing provider or their staff.)

Description of Items Being Requested	HCPCS Code	Modifier	Calories per Day	Units per Day	No. of Monthly Refills	Length of Need
1.						
2.						
3.						
4.						
5.						

SECTION 5

Provider of DME Attestation, Signature, and Date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.
For more information, please refer to Durable Medical Equipment Bulletin 31 and instructions for Section 5.

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DME Provider's Signature Date

(Wet and electronic signatures are acceptable. Signature and date stamps, or the signature of anyone other than the DME provider, are not acceptable.)

For wet signature, print legal name of provider ..... Date .....

Reset form

Member Name _____

SECTION 6

Section 6 must be completed by the member's prescribing provider or their staff.
Complete all items and attach any pertinent information (e.g., lab tests, medical history and physical examination, clinical notes, etc.).

A. Anthropometric Measures (Complete all items)

- ☐ Height:
- ☐ Basal Metabolic Rate (BMR):
- ☐ Body Mass Index (BMI):
- ☐ Weight:
- ☐ Growth Percentile (Child Only):
- ☐ Ideal Body Weight:

B. Laboratory Tests (Attach Results)

- ☐ Type of blood tests (specify):
- ☐ Type of urine tests (specify):
- ☐ Other tests (specify):

C. Risk Factors

- ☐ Anatomic structures of gastrointestinal tract that impair digestion and absorption
- ☐ Neurological disorders that impair swallowing or chewing (specify):
- ☐ Diagnosis of inborn errors of metabolism that require food products modified to be low in protein (specify):
- ☐ Intolerance or allergy to standard milk-based or soy infant formulas that have improved with a trial of specialized formula
- ☐ Prolonged nutrient losses due to malabsorption syndromes or short-bowel syndromes, diabetes, celiac disease, chronic pancreatitis, renal dialysis, draining abscess or wounds, etc. (specify type):
- ☐ Treatment with anti-nutrient or catabolic properties
- ☐ Increased metabolic and/or caloric needs due to excessive burns, infection, trauma, prolonged fever, hyperthyroidism, or illnesses that impair caloric intake and/or retention
- ☐ A failure-to-thrive diagnosis that increases caloric needs while impairing caloric intake and/or retention

Other (specify):

D. Route of Treatment

- ☐ Mouth (oral) only
- ☐ Nasogastric (NG-tube)
- ☐ Gastric (G-tube)
- ☐ Jejunal (J-tube)

Other (specify):

E. Treatment Regimen Initiated

- ☐ Past (explain):
- ☐ Last Six Months (explain):
- ☐ None (explain):

F. Other Information:

SECTION 7

Prescribing Provider's Attestation, Signature, and Date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in Section 2 of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.
Please refer to Durable Medical Equipment Bulletin 31 and instructions for Section 7.

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Prescribing provider's signature Date

(Wet and electronic signatures are acceptable. Signature and date stamps, or the signature of anyone other than the DME provider, are not acceptable.)

Check applicable credentials: ☐ MD ☐ NP ☐ PA ☐ CNS

For wet signature, print legal name of provider ..... Date .....

Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Enteral Nutrition Products

Sections 1, 2, 3, and 4 must be completed by the provider of DME or the prescribing provider. Section 5 must be completed by the provider of DME. Sections 4A, 6, and 7 must be filled out by the prescribing provider.

Instructions for using this Form	Providers of DME are instructed to use this form when obtaining a prescription and letter of medical necessity from the member's prescribing provider for enteral nutrition products, and as an attachment to a prior authorization (PA) request for enteral nutrition products. Providers of DME are responsible for ensuring compliance with applicable MassHealth regulations and guidelines when using this form. MassHealth reserves the right not to accept the form if it is completed improperly, or if the provider has failed to meet applicable MassHealth regulations, requirements, and guidelines, including, without limitation, medical necessity requirements. Please refer to the MassHealth Guidelines for Medical Necessity Determination for Enteral Nutrition Products for further information about required clinical documentation and information that must be submitted for PA requests for enteral nutrition products. A copy of this completed form (including all attachments and supporting documentation) must be maintained in the member's medical record at the prescribing provider's office and at the provider of DME's office.
Section 1	MassHealth does not require the date of delivery to be completed at the time the PA is submitted to MassHealth, but it must be entered on the form for recordkeeping purposes. The date of delivery at the top of page one of this form must match the date of initial delivery on the delivery slip in accordance with 130 CMR 409.419. Enter the member's name, MassHealth member ID number, address (including apartment number if applicable), telephone number, date of birth, gender, and applicable ICD diagnosis codes with their descriptions.
Section 2	Enter the prescribing provider's name, NPI, address, telephone, and fax numbers.
Section 3	Enter name of DME provider, NPI, address, telephone, and fax number.
Section 4	Enter the description of the enteral formulae and supplies being requested, and the HCPCS codes, and modifiers.
Section 5	The provider of DME must sign and enter the date the form was completed. By signing the form, the provider is making the certifications contained above the signature line. **The signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity (if the provider of DME is a legal entity), is not acceptable. Wet signatures or electronic signatures as defined in Durable Medical Equipment Bulletin 31 are acceptable.** MassHealth will accept provider signatures executed by an authorized signatory in any of the following formats. 1. Traditional "wet signature" (ink on paper) 2. Electronic signature that is either: a. Hand-drawn using a mouse or finger if working from a touch screen device b. An uploaded picture of the signatory's hand-drawn signature 3. Electronic signatures affixed using an appropriate digital tool including, but not limited to: a. Adobe Sign b. DocuSign If using an electronic signature, the signature must be visible, include the signatory's name and title, and must be accompanied by a signature date. One of the following notations must be included to indicate that the signatory's name, typically applied in typed format, was electronically signed. • Electronically signed by • Authenticated by • Approved by • Completed by • Finalized by • Signed by • Validated by • Sealed by

Sections 4A, 6, and 7 must be completed by the prescribing provider.	
Section 4A	If the member is being tube fed (BA modifier), the prescribing provider must enter the number of calories per day that the member is expected to obtain from the enteral formulae listed. If the member requires oral enteral nutrition (BO modifier), enter the units (1 unit = 1 can) of enteral products requested per day. Enter the length of need (in months) that the prescribing provider expects the member to require products and supplies requested (not to exceed 12 months from the date of the original prescription).
Section 6	The member's prescribing provider or the provider's staff must complete the medical justification for the requested product(s). This section must be filled in, and applicable supporting documentation must be attached.
Section 7	The member's prescribing provider listed in Section 2 of this form must review all information completed on and attached to this form, and must sign and date the form. By signing the form, the prescribing provider is making the certifications contained above the signature line. The form must be signed by the member's prescribing provider, who must be either the member's physician (MD), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). **The prescribing provider must check the applicable credential(s). Wet signatures or electronic signatures as defined above and in Durable Medical Equipment Bulletin 31 are acceptable. Please also refer to Section 5 above for information and requirements for wet and electronic signatures.**

If you have any questions about how to complete this form, please contact the MassHealth LTSS Provider Service Center at **(844) 368-5184.**