DOME HOME CARE
24 15TH STREET SUITE 205
BROOKLYN, NY 11215
(718) 854-5501
Provider # 4450490001

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Beneficiary Name: DOB: Effective Date:
Address: HICN:
City, State, Zip: Date seen prior to current visit: _____

DIAGNOSIS ICD10: _____ _____ _____ _____ **HT:** ***WT:**

HCPCS CODE	ITEM DESCRIPTION	QTY
B9002	ENTERAL PUMP W/ALARM	1
E0776	ENTERAL IV POLE	1
B4035	ENTERAL FEEDING BAGS PUMP FED PER DAY	30
B41___	**ENTERAL FORMULA:** _____	____
	CALORIES PER DAY: _____	
******	**Flow Rate:**_____; **Hrs:**_____	
B4087	GASTROSTOMY FEEDING TUBE SIZE: _____	1 (PER 3 MNTHS)
A4320	IRRIGATION KIT W/ SYRINGES	8

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

Patient has: **(CIRCLE ONE & ADD APPLICABLE DX)**

(a) permanent (or at least 3 months)non-function or disease of the structures that normally permit food to reach the small bowel

ICD/10 CODE(S): _____ _____ _____ _____

(b) disease of the small bowel which impairs digestion and absorption of an oral diet,

ICD/10 CODE(S): _____ _____ _____ _____

Either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.

PHYSICIAN NAME: UPIN:
ADDRESS: NPI#:
CITY, STATE, ZIP: NYS LIC:

_____ _____
PHYSICIAN SIGNATURE DATE

**** NOTE TO PHYSICIAN: BY SIGNING THIS DOCUMENT YOU ARE VERIFYING THERE IS SUPPORTING DOCUMENTATION IN PATIENTS PERMANENT MEDICAL RECORDS AND THIS DOCUMENTATION IS AVAILABLE UPON REQUEST.**

DOME HOME CARE

Documentation To Verify the Need for Enteral Feeding Pump

DOCTOR: _____ PHONE: _____

_____ UPIN: _____

_____ NPI: _____

Dear Doctor:

Medicare and insurance carriers require that physicians complete a verification outlining the need for an enteral feeding pump

Patient Name: _____ Date Ordered: _____

HIC#: _____ Caid # _____

Items Ordered: B9002 Enteral Feeding Pump; B4035 Enteral Feed Kits pump fed per day

Formula Ordered: _____ Calories per day _____

Is the patient able to tolerate bolus or gravity feedings? Yes No

If "no", what signs of intolerance or complication does the patient exhibit while using a bolus or gravity method?

_____ Reflux and/or aspiration

_____ Diabetis (needs slow infusion rate to regulate glucose level)

_____ Hx of diarrhea with other feeds

_____ Dumping Syndrome

_____ Hx Aspiration Pneumonia

_____ Jejunostomy tube feeding

_____ Fluid retention

_____ Circulatory Overload

_____ Reflux disorder

_____ Persistent Nausea/ Vomiting

_____ Renal Disease

_____ Administration rate less than 100ml/hr

_____ CHF

_____ Fetal position

Other (Please Explain) _____

_____

Level of Conciousness:

_____ Comatose _____ Semi-Comatose _____ Responsive

By signing this form you are certifying that the above information is documented in the patient's permanent record

Physician Signature: _____ Date: _____