Michigan Department of Health and Human Services

CERTIFICATION OF MEDICAL NECESSITY (CMN) FOR ENTERAL FORMULAE, SUPPLIES AND EQUIPMENT

PROVIDER'S Name (Last, First, Middle Initial)	Provider NPI Number	Phone Number
Provider's Address (Number & Street, Ste., City, State, ZIP Code)		Fax Number
BENEFICIARY'S Name (Last, First, Middle Initial)	MIHealth Card Number	Birth Date – mm/dd/yyyy / /
	Sex ☐ **M** ☐ **F**	Does Beneficiary Reside in a Nursing Care Facility? ☐ **YES** ☐ **NO**
PRESCRIBING PHYSICIAN'S Name (Last, First, Middle Initial)	Provider NPI Number	Phone Number
Prescribing Physician's Address (Number & Street, Ste., City, State, ZIP Code)		Fax Number

FORMULAE PROCEDURE CODES AND DESCRIPTIONS	DISPENSED HOW ORAL	DISPENSED HOW TUBE	VOL. / DAY (oz., ml., gms.)	UNITS / DAY (cans, packets, etc.)
1.	☐	☐		
2.	☐	☐		
3.	☐	☐		

ENTERAL SUPPLIES / EQUIPMENT with DESCRIPTION	NUMBER OF ITEMS PER MONTH
1.	
2.	
3.	
4.	

MUST Be Completed by PRESCRIBING PHYSICIAN'S OFFICE:

Formula Prescription Is: ☐ **FIRST TIME PRESCRIBED** ☐ **CONTINUATION**	Beneficiary Weight	Beneficiary Height	Date Measured (mm/dd/yyyy) / /
Diagnoses and Medical Necessity for Services Prescribed			
Diet Order and Restrictions	Specific Formula Required		
Total Calories Required by Patient Per Day	Dietary Formula Represents: ☐ **TOTAL DIET** ☐ **SUPPLEMENTAL FEEDING**		
Expected Duration of Use	Dates of Prescription (Begin Date and End Date)		

Stamped Signatures are NOT Acceptable

I certify ☐ re-certify ☐ that I have examined the patient named above and have determined that the above formulae and/or supplies/equipment are medically necessary.

Physician Signature Date

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary.

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