Michigan Department of Health and Human Services

Medical Justification for Enteral Therapy

If faxed, this form MUST be submitted with a completed MSA-1653-B, including all requested enteral therapy procedure codes.

The Durable Medical Equipment (DME) provider can only provide answers to the following fields: Beneficiary ID Number, First and Last Name, Date of Birth (DOB), type of enteral formula therapy requested, and formula requested. The ordering practitioner or practitioner's designated clinical staff (e.g., dietician, registered nurse, or other appropriate hospital clinical staff) must complete all other fields. Form must be typewritten.

1. Beneficiary ID Number:	2. Date of Birth:
3. Beneficiary Name (First):	4. Beneficiary Name (Last):
5. Diagnosis/Patient History (related to the need for formula):	
6. Height and Weight (current within 30 days of request):	7. Date Measured:
8. Current BMI (weight/height ratio if < 3 years old):	
9. Height (in, cm) and Weight (lb, kg) Change Over Time:	
10. For coordination of care purposes, are there any other insurances or programs covering formula for this beneficiary? ☐ No ☐ Yes. If yes, please indicate the insurance or program and formula.	

Enteral Formula Number 1	
11. Type of Enteral Therapy Requested: ☐ Formula ☐ Thickener ☐ Relizorb	
12. Route of Administration: ☐ Oral ☐ Tube Feed	
13. Formula Requested:	14. Type of Diet:
15. Total Daily Caloric Requirement:	16. Amount/Day (Calories) of Formula:
17. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:	

Enteral Formula Number 2	
18. Type of Enteral Therapy Requested: ☐ Formula ☐ Thickener ☐ Relizorb	
19. Route of Administration: ☐ Oral ☐ Tube Feed	
20. Formula Requested:	21. Type of Diet:
22. Total Daily Caloric Requirement:	23. Amount/Day (Calories) of Formula:
24. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:	

Enteral Formula Number 3	
25. Type of Enteral Therapy Requested: ☐ Formula ☐ Thickener ☐ Relizorb	
26. Route of Administration: ☐ Oral ☐ Tube Feed	
27. Formula Requested:	28. Type of Diet:
29. Total Daily Caloric Requirement:	30. Amount/Day (Calories) of Formula:
31. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:	

32. Ordering Practitioner Name:	33. Ordering Practitioner Specialty/Subspecialty:
34. Ordering Practitioner Signature:	35. Date:

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary but is required if payment from applicable program is sought.

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