Preauthorization Request for Oral Nutrition

Date________________

Please indicate if this is a new request or recertification.

__ New Request __ Recertification

Approved Through Date____________

(Services required beyond approval date will require a new authorization.)

PATIENT INFORMATION

Name________________________________ BCBSRI Member ID____________________________

Date of Birth____________________________ Phone Number________________________________

Address____

PROVIDER INFORMATION

Name________________________________ Tax ID____

Phone Number_________________________ Fax Number__________________________________

Oral enteral nutritional formulas or special medical formulas are only approved for malabsorption caused by certain conditions.	Low protein food products are only approved for certain conditions or inborn errors of metabolism.
Please select the appropriate condition(s). __ Crohn's disease __ Ulcerative colitis __ Gastroesophageal reflux __ Chronic intestinal pseudo-obstruction __ Other (Please specify.)_____________	Please select the appropriate condition(s). __ Phenylketonuria (PKU) __ Tyrosinemia __ Homocystinuria __ Maple syrup urine disease __ Propionic aciduria __ Methylmalonic aciduria __ Other (Please specify.)_____________

MEDICAL DIAGNOSES – Provide ICD-10-CM Code(s) and Description(s)

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SPECIALIZED NUTRITION – Product(s) Requested

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PHYSICIAN'S SIGNATURE

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