Enteral Nutrition **and Supplies Prior Authorization Request** Form

Effective February 1, 2020, all Family Care services require authorization through the member's care team. Do not use this form for authorization. If you require assistance connecting with the member's care team, contact the My Choice Wisconsin Customer Service Center at 1-800-963-0035. For other programs, please fax this completed form to 608-210-4050. Please provide clinical information to support medical necessity of all requests and fill form completely.

Member Name:	**D.O.B.:**	**Medicaid ID #:**
Member Phone:	**Member address:**	
Prescriber Name/Clinic:		**Tax ID:**
Address:		
Clinical Contact/Title:	**Phone Number:**	**Fax Number:**
Servicing Provider Name/Clinic:		**Tax ID:**
Address:		
Clinical Contact/Title:	**Phone Number:**	**Fax Number:**

Request Type? ◯ **Standard** ◯ **Expedited: Please explain rationale for urgency:**
Expedited is defined as: Care and services that the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

Diagnosis or description of symptoms: **ICD-10:**

Indicate how the enteral nutrition product(s) prescribed or ordered will be administered.

- ◯ Feeding tube only
- ◯ Mouth only
- ◯ Mouth and feeding tube

If the enteral nutrition product will be administered using both mouth and feeding tube, indicate the following:
Calories per day administered orally: _____
Calories per day administered via feeding tube: _____

Procedure Code	Modifiers, if Applicable	Product Trade Name	Calories per Day Requested	Number of Days Requested	Units Requested for Nutrition *(calories per day x number of days/100)*

Current height: _____ inches Date measured: _____
Current weight: _____ pounds Date measured: _____

Privacy and Confidentiality:

The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 1-800-963-0035 (phone) or 608-210-4050 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

No Guarantee of Payment

A prior authorization or pre-certification does not imply or guarantee payment, nor is it a verification of a member's eligibility at the point of service. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the program's contract and eligibility of the member at the time services are rendered. Reimbursement is based on Medicare and Medicaid rules, regulations, and fee schedules unless contractually excepted.