

Letter of Medical Necessity
Enteral and Nutritional Products

Date:

Patient's Name:		DOB:			
MEDICAID ID #:					
Height	cm	%ile/age	Weight	kg	%ile/age
Ideal Body Weight	kg	%ile Ideal Body Weight			
Date Obtained:		Diagnosis:			

Dear Medical Reviewer,

The following is a medical explanation and justification of why we are recommending our patient receive medical nutritional products:

See the attached growth charts for patient's growth history:

- The patient has remained below the 5th%weight for height or BMI for age
- The patient has lost kg in months.
- The patient is years old with the average height age of years and weight age of years.
- The patient has shown positive weight gain with nutritional supplementation

Documentation why the patient cannot be maintained on an age appropriate diet:

- The patient has increased metabolic rate secondary to .
- The patient has failed trials with increased caloric density of foods and more frequent feedings.
- The patient has documented dysphagia and is at risk for aspiration. All liquids are to be thickened to a _____consistency.
- The patient has poor feeding skills (i.e. difficulty chewing, poor hand to mouth coordination) and requires nutrient dense supplements in order to limit length of feeding and maximize nutrient intake.
- Diet type: *Total number of cans or calories per day needed by the patient:*

Does the supplement provide greater than 50% of the patients energy needs? Yes No

Does the patient have a gastrostomy tube? Yes No

Physician

Clinical Dietician