

**CERTIFICATE OF MEDICAL NECESSITY**  
**NUTRITIONAL THERAPY**

All of the following information is required in order for nutrition to be covered. This form must be contained in the recipient's clinical records.

RECIPIENT NAME: \_\_\_\_\_

MEDICAL ASSISTANCE ID NUMBER: \_\_\_\_\_



**DIAGNOSIS** – INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS NUTRITION REQUEST:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROGNOSIS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HOW LONG IS THIS PROBLEM EXPECTED TO LAST?

MONTHS \_\_\_\_\_ INDEFINITELY \_\_\_\_\_ PERMANENTLY \_\_\_\_\_

**EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR AUTHORIZATION:**

INDIVIDUAL'S SOLE SOURCE OF NUTRITION YES \_\_\_\_\_ NO \_\_\_\_\_

INDIVIDUAL RESIDES AT HOME YES \_\_\_\_\_ NO \_\_\_\_\_

NUTRITION BEING PRESCRIBED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



PROVIDER NAME AND ADDRESS \_\_\_\_\_

PROVIDER IDENTIFICATION NUMBER \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_