Preauthorization Request for Oral Enteral Nutrition

New Request ☐ Recertification ☐

Today's date: _____

Approved through: _____
(To be completed by BCBSRI. Services required beyond approval date will require new authorization)

PATIENT INFORMATION

Patient Name: _____ Patient ID#: _____ Date of Birth: _____

Patient Address: _____

_____

Patient Phone#:_____

PROVIDER INFORMATION

Physician Name: _____ Physician Phone: _____ Fax#: _____ Tax ID#: _____

Oral enteral nutritional formulas or special medical formulas are only approved for malabsorption caused by:	**Low-protein food products are only approved for certain conditions of inborn errors of metabolism such as, but not limited to:**
(Please select the appropriate condition(s)	**(Please select the appropriate condition(s)**
☐ Crohn's disease	☐ Phenylketonuria (PKU)
☐ Ulcerative colitis	☐ Tyrosinemia
☐ Gastroesophageal reflux	☐ Homocystinuria
☐ Chronic intestinal pseudo obstruction	☐ Maple syrup urine disease
☐ Other _____	☐ Propionic aciduria
	☐ Methylmalonic aciduria
	☐ Other (specify): _____

Provide Medical Diagnoses
(ICD-9-CM Codes and Description):
_____

Specialized Nutrition
Product(s) Requested:
_____

_____
Physician's Signature:

_____

Fax preauthorization form to BCBSRI After Care Department at (401) 459-5587.

Please send a copy of the form to the member on approval as this information is needed for reimbursement.