

Certificate of Medical Necessity

UPMC Health Plan UPMC *for Life* UPMC *for You*

To: UPMC Health Plan
Ancillary Coordinator
Phone: 1-800-425-7800
Fax: 412-454-5255

From:
Facility:
Phone:
Fax:

Please complete all sections of this form

1. Patient Last Name: _____ Patient First Name: _____

2. Date of Birth: _____

3. Agreement Number: _____

4. Diagnosis and ICD 9 Code: _____

5. Therapy Start Date: _____ Authorization End Date: _____

6. Name of Nutritional Product: _____

7. Oral Nutritional Supplement: Yes No

8. Enteral Feeding: Yes No

9. THIS SECTION TO BE COMPLETED BY PHYSICIAN'S OFFICE

Sole Source of Nutrition: Yes No

Amount per Feeding/Frequency: _____

Total Calories Required Per Day: _____

Estimated Percentage of Total Caloric Intake from Feeding: _____

Date of Last Office Visit and/or Hospitalization: _____

Current Height/Weight: _____

Additional Clinical Information:

Physician Signature _____ Date _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____