Indiana Health Coverage Programs
Durable Medical Equipment Information Form

Enteral and Parenteral Nutrition

All information on this form may be completed by the supplier.

Certification Type/Date: **Initial** _____ **Revised** _____ **Recertification** _____

Patient name Address Phone number _____ IHCP Member ID _____	Supplier name Address Phone number _____ IHCP Provider ID_____
Place of service _____ Name and address of facility, if applicable *(see reverse)* Supply item/service procedure code(s): _____ _____ _____ _____	PT DOB _____ Sex ___(M/F) Ht. _____(in) Wt. _____(lbs.) Physician name Address Phone number _____ IHCP Provider ID_____
Est. length of need (# of months): _____ 1–99 *(99=Lifetime)*	Diagnosis codes: _____ _____ _____ _____

Answer questions 1–6 for enteral nutrition, and 6–9 for parenteral nutrition (Check Y for Yes, N for No, unless otherwise noted)	**Answers**
1. Is there documentation in the medical record that supports the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?	☐ Y ☐ N
2. Is the enteral nutrition being provided for administration via tube? (i.e., gastrostomy tube, jejunostomy tube, nasogastric tube)	☐ Y ☐ N
3. Print supply item/service procedure code(s) of product.	A) _____ B) _____
4. Calories per day for each corresponding supply item/service procedure code(s).	A) _____ B) _____
5. Check the number for method of administration? 1 – Syringe 2 – Gravity 3 – Pump 4 – Oral (i.e., drinking)	☐ 1 ☐ 2 ☐ 3 ☐ 4
6. Days per week administered or infused (Enter 1–7)	_____
7. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?	☐ Y ☐ N
8. Formula components: Amino Acid _____(ml/day) _____concentration % _____gms protein/day Dextrose _____(ml/day) _____concentration % Lipids _____(ml/day) _____days/week _____concentration %	
9. Check the number for the route of administration. 1 – Central Line (Including PICC) 2 – Hemodialysis Access Line 3 – Peritoneal Catheter	☐ 1 ☐ 2 ☐ 3

Supplier Attestation and Signature/Date

I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

Supplier signature_____ **Date** _____

Instructions for Completing the IHCP DME Information Form: Enteral and Parenteral Nutrition

Certification Type/Date:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "Initial." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "Initial," and also indicate the revision date in the space marked "Revised." If this is a recertification, indicate the initial date needed in the space marked "Initial," and also indicate the recertification date in the space marked "Recertification." Whether submitting a Revised or a Recertification DME Information Form, be sure to always furnish the Initial date as well as the Revised or Recertification date.
Patient information:	Indicate the patient's name, permanent legal address, telephone number and IHCP Member ID as it appears on their IHCP member card and on the claim form.
Supplier information:	Indicate the name of your company (supplier name), address and telephone number along with your IHCP Provider ID.
Place of service:	Indicate the place in which the item is being used. For example, patient's home is 12, skilled nursing facility (SNF) is 31, End-Stage Renal Disease (ESRD) facility is 65, and so on.
Facility information:	If the place of service is a facility, indicate the name and complete address of the facility.
Supply item/service procedure code(s):	List all procedure codes for items ordered that require a DME Information Form. Procedure codes that do not require certification should *not* be listed in this section of the form.
Patient DOB, height, weight and sex:	Indicate patient's date of birth (MM/DD/YY), sex (male or female), height in inches and weight in pounds, if required.
Physician information:	Indicate the physician's name, complete mailing address, telephone number (where the physician can be contacted if more information is needed, preferably where records would be accessible pertaining to this patient) and IHCP Provider ID.
Established length of need:	Enter the number of estimated months the item(s)/service will be needed (for lifetime, enter 99).
Diagnosis codes:	Enter up to four applicable diagnosis codes for the patient's condition related to item(s)/service indicated.
Question section:	This section is used to gather clinical information about the item or service billed. Answer each question that applies to the items ordered (questions 1–6 for enteral nutrition; questions 6–9 for parenteral nutrition).
Supplier attestation:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
Supplier signature and date:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.