HSCSN Order for NUTRITIONAL SUPPLEMENT

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: **UM@hschealth.org.**
IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.

DATE OF REQUEST:	
PROVIDER	**MEMBER**
Ordering Provider (MD or NP):	**Member Name:**
Provider NPI #:	**Member ID:** **DOB:**
Provider Phone #: **Fax #:**	**Primary Diagnosis:**
Provider Email:	**Other Diagnoses:**

SUPPLEMENT REQUESTED (Include schedule of supplement):
Routed: ☐By Mouth ☐By Tube ☐ Combo

Name of Supplements: Amount/Schedule:

Proposed Duration of Use: ☐1 month ☐3 months ☐6 months ☐12 months

MEDICAL NECESSITY:
Medical Necessity Explanation:
☐ Weight Loss ☐ Dysphagia ☐ Poor Weight Gain ☐ Obesity ☐ Metabolic Disorder

☐ Please explain why this supplement is needed:

☐ Growth Chart – **REQUIRED DOCUMENT** ☐Nutritional Evaluation – OPTIONAL Date, if applicable

Most recent: Weight kg Height cm BMI
Date of Measurements:

☐ Describe Current Feeding Plan:

Has an evaluation been done by: ☐Gastroenterologist (GI) ☐Endocrinologist ☐Nutritionist ☐Occupational Therapist ☐Speech Therapist ☐ Genetic Physician ☐ Metabolic Physician

Community Referrals:
Do you plan to make any referrals for evaluation/treatment of this problem?

☐Gastroenterologist (GI) ☐Endocrinologist ☐Obesity Clinic ☐Weight Management ☐Occupational Therapy
☐Feeding Clinic ☐Speech Therapy ☐Other

Is there any additional information you would like to provide:

Signature of Ordering Provider: Date:

Printed Name: