Physician's Written Order

Enteral Nutrition

To request free samples for your patient, please email us at hello@trilityhealth.com.

Customer Care can help your patient navigate the insurance process and connect them with an in-network home medical supplier.

PATIENT

First	MI	Last		
DOB	Gender	Height		Weight
Street	City	State.	Zip	
Phone	Email			
Caregiver Contact	Phone	Email		Relationship

INSURANCE

Primary Insurance Policy Holder Name	DOB	Secondary Insurance Policy Holder Name	DOB
Primary Insurance	Phone	Secondary Insurance	Phone
Policy/ID	Group #	Policy/ID	Group #

Patient's Current Home Medical Supplier

PRESCRIBING PHYSICIAN

First	MI	Last	
Street	City	State	Zip
Phone	Fax	NPI#	

DIAGNOSIS

Start Date:____/____/_____ Estimated Length of Need:_____months (99 = lifetime)

ICD-10 Diagnosis Code:_____

1. if enteral nutrition is being routed for administration via tube, please indicate the route:

☐Gastronomy Tube ☐Jejunostomy Tube ☐Nasogastric Tube ☐Other

2. Quantity to Dispense PER DAY: _____stick packs

3. Please indicate feeding plant (amount and frequency):_____

4. Method of administration of the enteral nutrition is (check all that apply):

☐Pump ☐Syringe ☐Gravity ☐Oral

5. Formula type/s used to fill order: **DISPENSE AS WRITTEN, NO SUBSTITUTIONS.**

☐TRILITY ACEND, Medical Food, Chronic Inflammation, Pineapple

Medical records may be required for insurance coverage. Please send this form, insurance cards and appropriate clinical documentation to the medical supply company.

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. To the extent that I provide any information to TRILITY relating to the patient above, I certify that I have received the proper consent from the patient, will provide a copy to TRILITY upon request, and will indemnify TRILITY.

Physician/Practitioner Signature: _____ Date:_____

(Stamps are not acceptable)

Printed Name: _____