Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593

ENTERAL NUTRITION

PRIOR AUTHORIZATION REQUEST

BENEFICIARY INFORMATION

Beneficiary name: _____

Beneficiary Medicaid ID #: _____ Date of birth: _____/_____/_____

PROVIDER INFORMATION

Provider name: _____ Provider Medicaid ID #: _____

Provider contact person: _____

Telephone number: (_____)_____ Fax number: (_____)_____

MEDICAL NECESSITY INFORMATION

1) Enteral nutrition diagnosis: _____

2) Does beneficiary live at home? Yes☐ No☐

3) Is home health involved with beneficiary's care? Yes☐ No☐

If so, which home health agency? _____ Phone #: (____)_____

4) Is enteral nutrition sole source of nutrition? Yes☐ No☐

If no, explain what other source of nutrition beneficiary is receiving and the approximate number of calories derived from additional source of nutrition._____

_____

5) Name of formula: _____ HCPCS code:_____

6) Calories per day from enteral nutrition: _____

7) What type of feeding tube does the beneficiary have in place? _____

8) Status of medical condition such as stable or declining: _____

9) Feeding kits requested: _____ HCPCS code: _____

10) If pump or pump supplies are being requested, indicate medical necessity: _____

_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or 785-274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.

Prior Authorization: 1-800-933-6593