Medical Service Company

Select Branch

ENTERAL Fax Order Form

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____ ***Date Prescribed:*** _____ /_____ /_____

Address: _____ # of Refills:_____

City/Zip: _____ Diagnosis: _____

Home Phone/Cell#: _____ _____

Date of Birth: _____ _____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

ENTERAL FEEDING EQUIPMENT & SUPPLIES

Name of Formula(s):_____

Ok to use equivalent formula?: ☐ Yes ☐ No

Calories per day for each formula: _____

Days per week administered or infused (Enter 1-7): _____

Route of administration: ☐ NG ☐ Gastrostomy Tube ☐ Jejunostomy Tube

If using pump, infusion rate (mL per hour/hours per day): _____

Please select one of the following:

☐ Syringe / Bolus (Syringe Kit – Qty 30/month)

☐ Gravity / IV Pole (Gravity Kit – Qty 30/month)

☐ Pump / IV Pole (Pump Kit – Qty 30/month)

☐ Oral (Formula)

Additional Supplies, if needed:

☐ NG Tube ☐ Mickey ☐ Mini One Fr:_____ cm:_____ ☐ Extension Sets

☐ Other (specify): _____

☐ Other (specify): _____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing equipment.
Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND

1) Patient Name ***2) Date Prescribed*** ***3) Physician Signature & Signature Date*** ***4) NPI*** ***5) Physician Name***

Physician's Signature: _____ ***Date:*** _____/_____/_____

Physician's Printed Name: _____ Ph: _____ Fax: _____

NPI: _____

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