**ATTACHMENT C**
**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**
**CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS FOR MEMBERS 21 YEARS OF AGE OR GREATER -INITIAL OR ONGOING REQUESTS**

**MEMBER INFORMATION** Member's AHCCCS ID Number: _____ Contracted Health Plan: _____

Member's Name: _____ Date of Birth: _____
*Last* *First* *Initial*

Members' Address: _____

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Assessment performed by: _____ AHCCCS Provider ID: _____

Provider Specialty: _____ Telephone Number: _____ Assessment Date: _____

**TYPE OF REQUEST**

☐ Initial
☐ Ongoing

**TYPE OF NUTRITION FEEDING**

☐ Weaning from Tube Feeding
☐ Oral Feeding – Supplemental
☐ Oral Feeding –Sole Source
☐ Emergency Supplemental Nutrition

**PREFERRED SUPPLEMENT** Type: _____ Substitution Permissible: ☐ Yes ☐ No

**ASSESSMENT**: Supporting documentation dated within 3 months of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria listed below.

| **All of the Following Requirements Must be Met** |
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| The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment. |
| The member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources. |
| The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.) |
| The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. ** Refer to AMPM, Policy 310-GG. |

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current height, weight, and BMI. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

_____ _____
Submitting Provider Signature Date

_____ _____ _____
Printed Name Provider Type Contact Number