DELTADRUGS

Enteral Nutrition

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 800.700.6401 • **FAX:** 866.700.6401 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Address: _____

City, State, Zip: _____

Phone #: _____ 2nd Phone #: _____ Email: _____

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

Formula Needed: _____ Quantity: _____

Daily Sig: _____

Diagnosis: _____

Patient experience:

❑ Vomiting	❑ Fatigue	❑ Dry mouth	❑ Early Satiety Thrush	❑ Taste Alteration
❑ Diarrhea	❑ Nausea	❑ Difficulty chewing/swallowing	❑ Poor Appetite	❑ GI Pain
❑ Difficulty Digesting Solids	❑ Oral Infection	❑ Oral Infection	❑ Suffering from Malabsorption	

JUSTIFY NEED OR CONTINUATION

_____

_____

_____

_____

❑ I have reviewed my patient's medical records and the items requested above. I verify that this patient's medical condition requires the products and the usage quantities are medically necessary for the patient. I will maintain a copy of this prescription in the patient's file to meet carrier documentation requirements.

Authorization Period: _____ To: _____ Refill: _____

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____

Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.

KINDLY ATTACH CLINICAL NOTES AND LABS AND FAX TO 866.700.6401