EXHIBIT 1240-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(ALTCS MEMBERS 21 YEARS OF AGE AND OLDER)

SUBMITTED BY:

Provider Name: ____

Provider AHCCCS ID Number: ____________________ Telephone: ____________

MEMBER INFORMATION

Member's Name: ______________________________ Date of Birth: ____________
Last First Initial

Member's AHCCCS ID Number: ______________ Enrollment: ____________________
(ALTCS Contractor)

Member's Address: ____

____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: ____________________ ____________________

AHCCCS Provider ID: ____________________ Telephone: ____________

Date of Assessment: ______________

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Member's Diagnosis: ____

2. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. Check all that apply:

Criteria	
a. The member was at or below the 10th percentile on a nationally recognized height/weight or BMI chart for their age and gender for 3 months or more. IBW = _______	
b. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment). Approximate weight loss = _______	
c. The member is able to consume/eat no more than *25*% of his/her nutritional requirements from normal food sources. Approximate % member is eating = _______	
d. Absorption problems are evidenced by emesis, diarrhea, dehydration, electrolyte imbalance, significant weight loss, etc. and intolerance/allergy to current food products has been ruled out.	
e. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. Pre and/or post-hospitalization. (No authorization required for the first 30 days.)	

3. Past nutritional counseling efforts and alternative nutritional feedings that were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used.)

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	**Source of Nutrition**
Weaning from Tube Feeding	
Oral Feeding - Sole Source (Authorization from the member's program contractor is required)	
Oral Feeding - Supplemental (Authorization from the member's program contractor is required)	
Emergency Supplemental Nutrition (No authorization is required for first 30 days)	

Additional Comments:

Nutritional Assessment Provider   Date

Member's PCP/Attending Physician   Date

EFFECTIVE DATE: March 1, 2000