



(844) 552-8813 • www.STYMCO.com

TO PLACE THIS ORDER...  
Fax to (813) 922-3152 OR  
Email to [verify@stymco.com](mailto:verify@stymco.com)



Completed  
Prescription Form



Patient Insurance  
& Address



Relevant  
Medical Notes

## Enteral Prescription Request/Letter of Medical Necessity

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ ☐ Male ☐ Female  
Is the patient being seen by home health services? ☐ Yes ☐ No  
Has the patient been notified of and chosen STYMCO for this order? ☐ Yes ☐ No

### PRESCRIPTION INFORMATION

Start Date: \_\_\_\_\_ Length of Need (months) : \_\_\_\_\_  
Number of Refills: \_\_\_\_\_  
Order Type: ☐ NEW (replace existing) ☐ ADD (supplement existing)  
Has patient been trained to use the prescribed equipment? ☐ Yes ☐ No

### PRIMARY DIAGNOSIS (REQUIRED)

☐ Z91.011 Allergy to milk products ☐ R13.12 Dysphagia ☐ K90.49 Malabsorption due to Intolerance, not elsewhere classified ☐ Other \_\_\_\_\_

### Route of Administration (Feeding type)

☐ Syringe (B4034) ☐ Feeding Pump Bags (B4035) ☐ Kangaroo ☐ Infinity ☐ Does patient need a Feeding Pump (B9002)? ☐ Gravity Bags (B4036)

### ENTERAL PRODUCTS

| PRODUCT TYPE        | CALORIES/DAY: | HCPCS: | Qty/30days | FREQ |
|---------------------|---------------|--------|------------|------|
| Formula:            |               |        |            |      |
| Formula:            |               |        |            |      |
| Formula:            |               |        |            |      |
| Formula:            |               |        |            |      |
| Formula:            |               |        |            |      |
| Total Calories/day: |               |        |            |      |

### ☐ TUBE FEEDING PROVIDES MAJORITY OF PATIENT'S NUTRITION

|                                                                      |                                                 |                               |      |      |
|----------------------------------------------------------------------|-------------------------------------------------|-------------------------------|------|------|
| <input type="checkbox"/> NG Tube (B4081/4082)                        | <input type="checkbox"/> NJ Tube (B4081/B4082): | <input type="checkbox"/> Oral |      |      |
| Brand:                                                               | Brand:                                          |                               |      |      |
| Size: FR Inch                                                        | Size: FR Inch                                   |                               |      |      |
| Qty:                                                                 | Qty:                                            |                               |      |      |
| <input type="checkbox"/> (B9998) Low Profile Tube type (G, J, or GJ) | Size: FR CM                                     | Other Enteral Supplies:       | Yes: | Qty: |
| Please Specify                                                       | Qty: /Days                                      | Farrel Bags:                  |      |      |
|                                                                      |                                                 | Connectors:                   |      |      |
|                                                                      |                                                 | Securement Devices:           |      |      |
| (B9998) Extension Sets Qty: /MO                                      |                                                 | Misc Items:                   |      |      |

Comments or add'l orders: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### PLEASE DATE/SIGN FORM AND ATTACH MOST RECENT CLINICALS/MD NOTES

### PRESCRIBER INFORMATION / APPROVAL

I, the undersigned, certify that this order is reasonable and medically necessary or it is as mandated benefit. this document is also written in the patient's record. The forgoing information is true, accurate, and complete. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**

Prescriber Name (Please Print): \_\_\_\_\_ Facility Name: \_\_\_\_\_  
Facility City/State: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ NPI #: \_\_\_\_\_

This form is designed to initiate a new order for products. Some payers may require STYMCO to verify this order or obtain prior authorization before the order can be shipped.

STYMCO is providing HCPCS/CPT codes based on information provided by the product manufacturers. STYMCO does not make representations about the accuracy of this information. The HCPCS/CPT codes do not indicate coverage or payment under any federal or state health care program. The entity that submits claims to any federal or state health care program has the responsibility to verify the accuracy of HCPCS/CPT codes it submits for payment purposes.