Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

ENTERAL ORDER FORM CHECKLIST

477 W HORTON RD.,BELLINGHAM, WA 98226
PH: 360-933-4892 / FAX: 360-933-1197

PATIENT INFORMATION:

Patient Name: _____DOB: _____

REQUIRED DOCUMENTATION FOR ENTERAL REFERRAL:

☐ Provide outpatient managing provider. Provider name:
_____

☐ Include an order from provider (“enteral nutrition managed by Infusion Solutions Inc”).
☐ Include patient facesheet, including social security number and a copy of the front & back of insurance card if available.
☐ Provide patient’s medication list.
☐ Include recent supporting clinical notes, such as H&P and last Registered Dietitian note.
☐ Include most recent labs and swallow studies to support diagnosis.
☐ Provide feeding tube placement confirmation.
☐ Medicare only: Requires the patient to have a permanent impairment and need for enteral nutrition of >90 days duration. This statement must be in a provider's progress note.

Infusion Solutions Inc will complete insurance verification and submit all required documentation for approval to the patient’s insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer the patient to any available co-pay assistance as needed. Thank you for the referral and using your locally owned independent infusion service.

Please fax all information to 360-933-1197 or call 360-933-4892 for assistance.

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