CONFIRMATION OF ORDER — Enteral

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: **Date of Birth:**

Order Date: **Insurance:**

Length of Need: 99 *(in months)*

Physician: **NPI:**

DIAGNOSIS

ICD 10 Code **Description**

PRESCRIPTION INFORMATION

Feeding Type:

Oral Bolus Gravity w/IV Pole Pump w/IV Pole

Enteral Brand: **Flavor:**

cans/day and/or calories/day times per day feeding or continuous

Feeding Tube:

Standard French CC Balloon Size B4087 *(Insurance will cover #1 per month)*

Mickey Low Profile French CM B4088 *(Insurance will cover #1 every 3 months)*

Feeding Kits:

Bolus (B4034) Pump (B4035) Gravity (B4036) Ready to hang (B4035)

(Insurance will cover #30 kits per month)

Normal Saline:

Flush cc before feeding Flush cc after feeding *(Insurance will cover 2000mL Normal Saline per month)*

60mL Syringe (B4322)**:**	**Fenestrated Gauze** (A6402)**:**
Quantity *(Insurance will cover #4 per month)*	2x2 4x4 Quantity *(Insurance will allow up to #200 per month)*

Other not listed:

Refills:

Physician Signature: ______________________ **Date:** ____________