KENTUCKY METABOLIC DISEASE PROGRAM

PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY – METABOLIC DISEASE THERAPY

Patient Name:_____ **Insurance:** _____

Address: _____ **Patient Number:**_____

_____ **Phone Number:** _____

Height: _____ Weight:_____ Date of Birth: _____

Confirmation Date:_____ Confirmation Test Results: _____

A. Primary Diagnosis: (ICD-10-CM Code plus Description) (please check one)

- ☐ E 70.0 Phenylketonuria
- ☐ E 71.2 Branched-chain Amino-Acid Disturbance, *specify* _____
- ☐ E 72.29 Urea Cycle Disorder, *specify*_____
- ☐ Other, *specify*_____

B. Pertinent medical history, diagnostic tests, treatment plan:

C. How often will patient be seen? _____ D. Date therapy initiated: _____

E. Formula prescribed? _____

F. Current Formula Recipe?_____

Authorizing Physician:

Name: _____ License Number: _____

Address:_____ Phone Number: _____

_____ Date patient last seen _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

- □ This is an initial certification
- □ This is a re-certification to expire _____

_____ _____

Physician's Signature Date

Update 2.8.19 wma