FAX

Date: ______________________

Number of Pages: ______________________

(including this cover page)

To: BMS/UMC EPSDT Service Medical Review

Phone: 1-800-346-8272

Fax Number: 1-866-209-9632

From: ______________________

Phone Number: ______________________

Fax Number: ______________________

Please include ALL the following documentation when submitting a prior authorization request for 100% enteral foods.

- ☐ **A completed EPSDT initial/periodic exam or interperiodic visit - page 1 of the HealthCheck Preventive Health Screening (PHS) Form.**
  Important Note:* *Medical home providers who utilize electronic health records (EHR) must submit a well child exam EHR printout and the HealthCheck PHS page 1 (child's name, birthdate, date of screen and provider signature only);
- ☐ **A completed EPSDT HealthCheck PHS page 2;**
- ☐ **A completed BMS/UMC EPSDT Prior Authorization Form (2 pages);**
- ☐ **A Children with Special Health Care Needs (CSHCN) Medical Foods Prescription Form;**
- ☐ **A history and physical (H&P is a child's history of their present condition. Documentation could include, but is not limited to a medical/health history form, past well child exams, labs and diagnostics, medications, hospitalizations and/or surgical procedures.) and;**
- ☐ **Other pertinent health information justifying the child's need for 100% enteral nutrition, which could include, but is not limited to; height and weight, swallowing evaluation and labs.**

Please retain a copy of this packet in your files for future reference

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