***Letter of Medical Necessity***

Date: Month, Day, Year

TO: Insurance Company  
FROM: Physician Name

SUBJECT: Request for coverage/ reimbursement for NUTREN® 1.5 Calorically-Dense Complete Nutrition Tube Feeding Formula.

I am requesting insurance coverage and reimbursement on behalf of my patient, Name/Date of Birth. I have prescribed NUTREN® 1.5 formula, manufactured by Nestlé Health Science, Inc. for the dietary management of Diagnosis or Condition.

*Verify medical necessity for formula, including: diagnosis, documented failure or intolerance to other formulas, current HT/WT/IBW, history of wt loss, pertinent lab results, medications, potential outcome if formula were denied.*

NUTREN® 1.5 formula is a calorically-dense (1.5 kcal/mL) nutritionally complete enteral formula for adults who have elevated calorie and protein needs, who may require a shortened feeding cycle, who require a fluid restriction, or who are intolerant to the volume of formula required to meet their calorie and protein needs. NUTREN® 1.5 formula is a medical food intended for use under the supervision of a medical professional.

NUTREN® 1.5 formula is recognized by the Centers for Medicare and Medicaid Services (CMS) as “an enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/mL) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube”, found in **HCPCS Category B4152**.

Thank you for taking the time to review this request. Please contact me should you require any additional information.

Sincerely,

Signature:  
Name:  
Title:

Attachments: *If relevant, include pertinent information supporting evidence of medical necessity and product information. Please refer to* [*www.NestleMedicalHub.com*](http://www.NestleMedicalHub.com) *for product information*.