***Letter of Medical Necessity***

Date: *Month, Day, Year*

TO: *Insurance Company*

FROM: *Physician Name*

SUBJECT: Request for coverage/ reimbursement for ISOSOURCE® HN High Nitrogen Tube Feeding Formula.

I am requesting insurance coverage and reimbursement on behalf of my patient, *Name/Date of Birth****.***I have prescribed Isosource® HNformula, manufactured by Nestlé HealthCare Nutrition, 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.*

Isosource® HN formula is a high nitrogen nutritionally complete enteral formula for adults who have normal or elevated calorie and/or protein needs and who require a short- or long-term tube feeding regimen. Isosource® HN formula is a medical food intended for use under the supervision of a medical professional.

Isosource® HN formula is recognized by the Centers for Medicare and Medicaid Services (CMS) as “an enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube”, found in **HCPCS Category B4150**.

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.NestleHealthScience.us*](http://www.NestleHealthScience.us) *for product information.*