EXHIBIT 430-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)

SUBMITTED BY:

Provider Name: _____

Provider AHCCCS ID Number: _____ Telephone: _____

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____
Last First Initial

Member's AHCCCS ID Number: _____ Enrollment: _____
(Contractor)

Member's Address: _____

_____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: _____

AHCCCS Provider ID: _____ Telephone Number: _____

Date of Assessment: _____

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. (At least two of the following must be met.) Check all that apply.

a. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for 3 months or more.	
b. The member has reached a plateau in growth and/or nutritional status for more than 6 months (prepubescent).	
c. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment).	
d. The member is able to consume/eat no more than 25% of his/her nutritional requirements from normal food sources.	
e. Absorption problems are evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products has been ruled out.	
f. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization (No PA for first 30 days).	
g. The member is at risk for regression due to chronic disease or condition.	

2. List past nutritional counseling efforts and alternative nutritional feedings which were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used).

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	**Source of Nutrition**
Weaning from Tube Feeding	
Oral Feeding - Sole Source (PA required)	
Oral Feeding - Supplemental (PA Required)	
Emergency Supplemental Nutrition (No PA required for first 30 days)	

Additional Comments:

_____ _____

Nutritional Assessment Provider Date Member's PCP/Attending Physician Date

Revised: 4/01/2007
Effective: 1/01/2000