Northwood/Well Sense Health Plan New Hampshire Medicaid Implementation
Enteral Batch Authorization Request Form

Provider Name: **Northwood Provider Number:**

Date: **Provider Contact:** **Provider Phone:**

Member Name (LAST)	Member Name (FIRST)	BMCHP ID #	Diagnosis Code(s) ICD9	HCPCS /BA or BO	Formula Name/Size/Type	Caloric Need per 24 hours	Ordering Physician Name & Phone Number	NH DHHS Authorization # (if applicable) AND End Date	Northwood Use Only Authorization Outcome
EXAMPLE: Smith	John	B1234567	693.1	B4161 BO	EleCare/14.1 oz. can/Powder	884 cal./24	Dr. Name, 603-555-1212	N67890000	

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EXAMPLE: Smith	John	B1234567	693.1	B4161 BO	EleCare/14.1 oz. can/Powder	884 cal./24 OR 44oz./24	Dr. Name, 508-555-1212		

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