

LETTER OF MEDICAL NECESSITY

Oral and Enteral Feeding Support

Patient Name: _____

Date of Birth: _____

Insurance ID: _____

Diagnosis (ICD-10): _____

Provider Name: _____

NPI Number: _____

To Whom It May Concern:

I am the treating healthcare provider for the patient listed above. Based on my clinical evaluation and ongoing management, I am prescribing Tink's Tonic whole-food powders as part of this patient's nutrition support plan.

The patient requires nutritional support due to a medical condition that affects their ability to meet nutritional requirements through a standard diet alone. Tink's Tonic whole-food powders are being recommended to support individualized nutrition goals and may be utilized for oral feeding and/or enteral tube feeding as clinically appropriate.

Tink's Tonic products consist of whole-food powdered ingredients that can be incorporated into customized nutrition plans under the supervision of the patient's healthcare team. These products may be used to help provide protein, fruit, and vegetable ingredients tailored to the patient's specific nutritional needs, tolerances, and feeding regimen.

Route of Administration (check all that apply):

- ☐ Oral Feeding Support
- ☐ Gastrostomy Tube (G-Tube)
- ☐ Jejunostomy Tube (J-Tube)
- ☐ Other: _____

Requested Products:

Estimated Daily Calories from Prescribed Products: _____ kcal/day

Length of Need: _____ Months _____ Lifetime

I certify that the prescribed nutrition products are medically appropriate for this patient and are recommended as part of their individualized nutrition plan. I respectfully request consideration for coverage and reimbursement in accordance with the patient's health benefit plan and applicable coverage policies.

Thank you for your consideration.

