

Insurance Co. NAME  
Address

Date: \_\_\_\_\_

## Letter of Medical Necessity

**SUBJECT: Request for coverage/reimbursement for enterade® Advanced Oncology Formula**

Dear Sir or Madam:

I am requesting insurance coverage and reimbursement for my patient, \_\_\_\_\_,  
for whom I have prescribed enterade® Advanced Oncology (distributed by Entrinsic Bioscience LLC).

enterade® is an amino acid-based, glucose free, medical food/beverage designed to rebuild and protect the GI tract and deliver optimal hydration for patients undergoing treatment for cancer and chronic GI dysfunction. It helps manages side effects such as diarrhea, nausea, vomiting, dehydration, and general GI symptoms along with promoting weight maintenance by rebuilding the GI's absorptive structures. enterade® supports long term digestive health in 3 ways: protects the GI to support healthy immune function by tightening the gut barrier, promotes optimal hydration by enhancing water and electrolyte absorption and rebuilds the GI tract by increasing villi growth.

enterade® Advanced Oncology is recommended twice a day and is medically necessary in this instance as an optimum management for my patient, \_\_\_\_\_, with a diagnosis of \_\_\_\_\_.

enterade® is suggested to be used under the supervision of a healthcare provider and its all-natural ingredients are recognized as a GRAS by FDA. The reimbursement codes for this product are 99422-0992-48 (orange flavor) and 28028-0353-89 (vanilla flavor). The assigned HCPCS codes for enterade are B4102 (Adults)/B4103 (Pediatrics).

Thank you for reviewing this request. Please contact me should you require any additional information.

Sincerely,

(Signature, Name of institution, Title, Phone or e-mail)

\*Note you may want to attach any pertinent medical information supporting your directive.