

Please fax completed 2-page form to: 877-777-0164

Phone: 800-365-7354, option 8, ext 1200

Service Requested

Please check all that apply:

<input checked="" type="checkbox"/>	Service	<input checked="" type="checkbox"/>	Service	<input checked="" type="checkbox"/>	Service
	Verify Insurance Benefits		Help with Prior Authorization Denial		Other - Please explain:
	Help with Prior Authorization		Help Finding a Supplier		

Attached Documentation (please check all that apply)

<input checked="" type="checkbox"/>	Documentation	<input checked="" type="checkbox"/>	Documentation	<input checked="" type="checkbox"/>	Documentation
	Patient Health Insurance Card (front & back)		Prescription		Office Notes
	Growth Chart		Lab Results		Letter of Medical Necessity
	Prior Authorization Request		Prior Authorization Denial		
	Other – Please Identify:				

Patient Information

Last Name	First	Middle Initial	Sex	Date of Birth	Weight (kg)
<hr/>					
Street Address	City	State	Zip Code	Home Phone	
<hr/>					
Name of Patient Representative to Contact if Necessary				Phone Number	

Health Insurance Information

(Please complete both Benefit sections)

Medical Benefit

Prescription Drug Benefit

Company Name _____	_____
Telephone _____	_____
Subscriber Name _____	_____
Relation to Patient _____	_____
Social Security _____ Date of Birth _____	_____ Date of Birth _____
Policy ID _____ Group _____	_____ Group _____

Authorization to Share Medical Information

I authorize Nutricia North America and its contracted agent to have access to all medical and insurance coverage information (Health Information) and records which pertain to the patient listed on this form, necessary to verify and/or obtain insurance coverage for the Nutricia product specified below. This information may include spoken or written facts about the patient’s medical condition or health insurance benefits. It may include copies of records from the physician or health plan outlining the patient’s medical history or treatment plan. I further understand that all information and documentation will be held in strict confidence and may only be used as allowed in this form. I know I can refuse to sign this form. I may withdraw it at any time and for any reason. This won’t affect the start or continuing of my treatment. It will have no effect on the quality of my treatment.

This authorization expires on January 1, 2019. If I change my mind before that time and do not want Nutricia North America to continue to share my Health Information, I can notify Nutricia North America of such revocation in writing, signed by me or on my behalf and delivered to Nutricia North America at 9900 Belward Campus Drive, Suite 100, Rockville, MD 20850. If I notify Nutricia North America in writing to stop sharing my Health Information, such notice will be effective upon receipt by Nutricia North America, but will not change any actions that Nutricia North America or others took in reliance upon this authorization before my effective revocation of this authorization.

Signature of Patient’s Representative	Relationship to Patient	Date
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Patient Name: _____

Please check all that apply:

<input checked="" type="checkbox"/>	Product	<input checked="" type="checkbox"/>	Product	<input checked="" type="checkbox"/>	Product
	Neocate® Infant DHA/ARA		KetoCal® 3:1 Powder		Complete Amino Acid Mix
	Neocate® Syneo™ Infant				
			KetoCal® 4:1 Powder		Essential Amino Acid Mix
	Neocate® Junior- Unflavored				
	Neocate® Junior- Chocolate		KetoCal® 4:1 Liquid- Unflavored		Peptide® Junior
	Neocate® Junior- Tropical		KetoCal® 4:1 Liquid- Vanilla		
					PhlexyVits
	Neocate® Jr w/Prebiotics- Unflavored		DuoCal®		
	Neocate® Jr w/Prebiotics- Strawberry		Liquigen®		
	Neocate® Jr w/Prebiotics- Vanilla		Monogen®		
	Neocate® Splash- Unflavored				
	Neocate® Splash- Grape				
	Neocate® Splash- Orange Pineapple				
	Neocate® Splash- Tropical				

<input checked="" type="checkbox"/>	Diagnosis	ICD-10 Codes	<input checked="" type="checkbox"/>	Diagnosis	ICD-10 Codes
	Allergic rhinitis due to food allergy	J30.5		Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus	G40.319
	Allergic and dietetic gastroenteritis and colitis	K52.29		Intestinal malabsorption, unspecified	K90.49
	Allergy to milk products	Z91.011*		Malabsorption due to intolerance, not elsewhere classified	K90.4
	Allergy to other foods	Z91.018*		Melena (bloody stools)	K92.1
	Other non-medicinal substance allergy status	Z91.048*		Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.411
	Dermatitis due to ingested food	L27.2		Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus	G40.419
	Eosinophilic colitis	K52.82		Other intestinal malabsorption	K90.89
	Eosinophilic esophagitis	K20.0		Postsurgical malabsorption, not elsewhere classified	K91.2
	Eosinophilic gastritis or gastroenteritis	K52.81		Underweight	R63.6
	Failure to thrive in newborn	P92.6		<5 th percentile for age	Z68.51*
	Failure to thrive (child)	R62.51		5 th percentile to < 85 th percentile for age	Z68.52*
	Gastro-esophageal reflux disease without esophagitis	K21.9		85 th percentile to < 95 th percentile for age	Z68.53*
	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.311		≥95 th percentile for age	Z68.54*
	Food protein-induced enterocolitis syndrome	K52.21			

Other, please list:

* Add-on codes

Tube Fed [] Yes [] No

Calorie Requirement Per Day _____

Ounce Requirement Per Day _____

Physician Signature _____

Date _____

Physician Name (Please Print) _____