Select Health Plan:

- ❑ HealthEase
- ❑ WellCare
- ❑ Staywell

FOOD SUPPLEMENT REQUEST FORM

Toll Free Fax (866) 825-2884

Children under 5 years of age, pregnant women and postpartum women must first register with the federal program for women, infants and children (WIC). A copy of the WIC statement must be attached to this form.

PHYSICIAN COMPLETE THIS SECTION – REQUIRED INFORMATION

Member ID# ____ DOB _____/_____/_____

First name _______________________________ M.I. ______ Last Name _______________________________

Prescriber Name _______________________________________ Specialty ______________________________

Contact Person __________________________________ Presciber Phone (______)____________________

Prescriber Fax (______)____________________

Food supplement requested:____

QTY___________ Cans/Scoops/Pkts Per Day Length of Therapy ______________________________

Diagnosis ____

Dosage and Frequency of dosing _______________________________________ ❑ Oral ❑ Tube Feeds

Height and Weight (required) _______ft______in ________ lbs Date measured _____/_____/_____

Comments ____

____

Consultation with a Registered Dietician? ❑ Yes ❑ No Date ____________ RD Name __________________

---

* * * **Required Physician Certification Statement** * * *

"I hereby certify that, without this food supplement, this patient will require institutionalization."

Signature ____________________________________ Date _________________

Please attach a copy of the original prescription. Attach lab results and other documentation as necessary.

For Internal Use Only