Coverage Assistance Form

How can we help you? (please check all that apply):

☐ **Benefit Verification** ☐ **New Referral/Supplier Search** ☐ **Other**____________________

Date: __________________ **Form Completed By:** __________________________

Phone (800) 605-0410 • Fax (301) 309-1156

Patient Demographics

Last Name:	First Name:	Middle Initial:	Tube Fed
			☐ Yes ☐ No

Date of Birth:	Age:	Social Security # (Optional – Not Required):	Gender:
			☐ Male ☐ Female

Home Street Address (include Apt #):	City:	State:	Zip Code:

Email Address:	Home / Cell Phone	Other Phone:

Disorder & Formula Usage

Disorder Name & Diagnosis	Current/New Formula (needing coverage assistance for):	Amount per Day:

Current DME/Infusion Provider and/or Pharmacy (Name & Ph#):	Previous Formula:

Clinic Information

Dietitian/Physician Name:	Clinic Name:	Phone #:	Fax #:

Responsible Party / Parent / Caregiver (Guarantor) Information

Relationship to Patient:

☐ **Parent** ☐ **Self** ☐ **Legal Guardian** ☐ **Other**__________________________

Last Name:	First Name:	Middle Initial:	Date of Birth:

Primary Insurance Information

Primary Insurance Name:	Phone Number:	Insured's ID#:	Group #:

RX Insurance Coverage:	Phone Number:	RX BIN#:	Rx PCN:	Rx Grp:

Secondary Insurance Information

Secondary Insurance Name:	Phone Number:	Insured's ID#:	Group #:

RX Insurance Coverage:	Phone Number:	RX BIN#:	Rx PCN:	Rx Grp:

Authorization for Release of Health Information

A separate HIPAA Authorization must be completed, signed and submitted with this form.

Please Mail, Fax or E-mail to: Nutricia North America , Attn: Coverage Dept. 10 Saddle Road, Cedar Knolls, NJ 07927 • Fax (301) 309-1156 • Email Coverage@Nutricia.com. Please attach a Letter of Medical Necessity and updated prescription (RX).

Authorization for Disclosure of Protected Health Information (PHI) by Healthcare Providers and Health Insurers and Use and Disclosure of PHI by Nutricia North America, Inc.

This Authorization allows my healthcare providers and my durable medical equipment or pharmaceutical suppliers (together, "healthcare providers") and health plans to disclose to Nutricia North America, Inc. and its third party contractors, agents, and assignees (together, "Nutricia") my protected health information ("PHI"). This Authorization also allows Nutricia to use and disclose my PHI. My PHI will include copies of my medical or other records from my healthcare provider or health plan outlining my medical history or treatment/management plan as well as my insurance benefits and coverage information.

The purpose of the disclosure and use is to allow Nutricia to:

- Provide me with Nutricia product specific reimbursement support services or patient assistance program guidance, including supplier referral set up,
- Help me navigate the various Nutricia product flavors and other product options that fall within the nutritional plan set by my healthcare provider and coordinate the stress-free supply of such products,
- Help me find additional Nutricia Metabolic diet support resources, education, recipes and other diet for life information to increase my enjoyment of my Nutricia products and Metabolic diet; and
- Work with my insurance carrier or other healthcare funding sources to try to help me get coverage, reimbursement or payment for Nutricia products.

I understand that once my PHI has been disclosed to Nutricia it may no longer be protected by federal privacy law and may be re-disclosed by Nutricia as a result.

I know I can refuse to sign this Authorization without impacting the start, continuation, or quality of my treatment, payment for treatment, clinic or insurance enrollment, or eligibility for insurance benefits or coverage. My healthcare provider and/or health plan cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I will not, however, be able to receive the Nutricia product support services set forth above from Nutricia.

I understand that I may revoke, cancel or withdraw this Authorization at any time and for any reason by sending a signed written letter to Nutricia at the following address: Nutricia North America, Inc., Attn: Coverage Dept., 10 Saddle Road, Cedar Knolls, NJ 07927. If I cancel this Authorization, my healthcare provider and/or health plan will no longer be able to provide Nutricia with information about me. I, however, may no longer be eligible to receive the Nutricia product support services set forth above. If I notify Nutricia in writing as set out above that I want to cancel this Authorization, such notice will be effective upon receipt by Nutricia, but will not change any actions that Nutricia or others took in reliance upon this Authorization before the date that I cancelled this Authorization.

This authorization expires 3 years from the date of my signature below unless otherwise specified. I understand that I have the right to receive a copy of this form from Nutricia.

I understand that Nutricia may contact me via email, telephone or mail to carry out the product support services referenced above.

Patient Authorization

I have read and understand the terms of this Authorization. By signing this form, I knowingly and voluntarily authorize the disclosure and use of my PHI. I agree that a copy of this form may be treated as a signed original.

____

(Patient, Parent or Guardian Signature)

____

(Patient's Printed Full Legal Name)

____

(Date)

____

(Patient Address: Street, City, Zip Code)

How would you prefer to be contacted?

- ■ Via phone:______________________________
- ■ Via email: ______________________________
- ■ Via mail: ______________________________

Please fax completed form to 1-301-309-1156 or email to Coverage@Nutricia.com. Provide a copy of this form to the patient and place the original in the patient's medical record.