Coverage Assistance Form

NUTRICIA
Advanced Medical Nutrition
Phone (800) 605-0410 – Fax (973) 734-0029

Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Nickname:

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

Home Street Address:	Apt#	City:	State:	Zip Code:

Email Address:	Employment Status:
	☐Child ☐Employed Full-Time ☐Employed Part-Time ☐ Unemployed ☐ Disabled ☐ Self Employed ☐ Student ☐ Other

Home Phone:	Work Number:	Other Phone:

METABOLIC DISORDER / FORMULA LIST AND USAGE

Disorder:	Current Formula(s):	Amount per day:	Current Pharm/DME:

CLINIC INFORMATION

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

RESPONSIBLE PARTY / PARENT / CAREGIVER (GUARANTOR) INFORMATION

Relationship to Patient:
☐ Self ☐ Spouse ☐Parent ☐Other: _____

Last Name:	First Name:	Middle Initial:	Phone Number #:

PRIMARY INSURANCE INFORMATION

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

Name of Primary Insured:	Primary's Date of Birth:	Relationship to Patient:

SECONDARY INSURANCE INFORMATION

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

Authorization for Release of Health Information

*This information contained herein may be shared with or reported to Nutricia North America and its affiliates for quality purposes to ensure that the necessary resources are available to service patients using our medical food products. Such information is furnished in compliance with HIPAA to allow for the best service of the patient. Nonetheless, if you or your patients do not wish for this information to be shared with Nutricia North America, please call 800-605-0410 and contact our **HIPAA Privacy Officer** that will assist with this request and ensure that the information is not shared.*

Please Mail, Fax or Email to: Nutricia North America 10 Saddle Road, Cedar Knolls, NJ 07927 ● Fax (973) 734-0029 ● Email Coverage@MedicalFood.com. Please attach a Letter of Medical Necessity and updated prescription (RX).