

## Nutricia Navigator Patient Information Form

**Please Fax Completed Form to: 877-777-0164**  
**Please Email Completed Form to: [nutricianavigator@nutricia.com](mailto:nutricianavigator@nutricia.com)**

**Phone: 800-365-7354**

### Service Requested

**Please check all that apply:**

	SERVICE		SERVICE
<input type="checkbox"/>	Verify Insurance Benefits	<input type="checkbox"/>	Help with Prior Authorization Denial
<input type="checkbox"/>	Help with Prior Authorization	<input type="checkbox"/>	Help Finding a Supplier

**Attached Documentation (please check all that apply)**

	DOCUMENTATION		DOCUMENTATION
<input type="checkbox"/>	Patient Health Insurance Card (front & back)	<input type="checkbox"/>	Prescription
<input type="checkbox"/>	Growth Chart	<input type="checkbox"/>	Lab Results
<input type="checkbox"/>	Prior Authorization Request	<input type="checkbox"/>	Prior Authorization Denial
<input type="checkbox"/>	Other - Please Identify:		

### Patient Information

Last Name	First	Middle Initial	Sex	Date of Birth	Weight (kg)
Street Address		City	State	Zip Code	Home Phone
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
Policy ID	Group

### Authorization to Disclose and Use Medical Information

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") protected health information ("PHI") about me related to my use or need for the products covered by Nutricia's Navigator Program. My PHI will include spoken or written facts, copies of my medical or other records from my healthcare providers 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 set out above is to allow Nutricia to verify and / or obtain insurance coverage for the Nutricia products specified below.

I understand that: (1) 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. (2) 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 because my healthcare provider and/or health plan cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, but I will not be able to receive services from Nutricia Navigator. (3) 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: 12862 Garden Grove Boulevard, Suite 240, Garden Grove, CA 92843. (4) If I cancel this Authorization, such cancellation will not change any actions that Nutricia or others took in reliance upon this Authorization before the date that I cancelled this Authorization. (5) This Authorization expires when my consideration for or participation in Nutricia Navigator ends. (6) I have the right to receive a copy of this form from Nutricia.

Patient Signature (if 18 or over) or Patient's Representative	Relationship to Patient	Middle Initial
---	-------------------------	----------------

**Patient Medical Information**

Patient Name \_\_\_\_\_

**Please check all that apply:**

SERVICE	SERVICE	SERVICE
Neocate® Syneo® Infant	KetoCal® 3:1 Powder	Complete Amino Acid Mix
Neocate® Infant DHA/ARA		
	KetoCal® 4:1 Powder	Essential Amino Acid Mix
Neocate® Nutra	KetoCal® 4:1 Liquid- Unflavored	
Neocate® Junior- Unflavored with Prebiotics	KetoCal® 4:1 Liquid - Vanilla	PhlexyVits
Neocate® Junior- Chocolate		
Neocate® Junior- Tropical	DuoCal®	
Neocate® Junior - Strawberry	Liquigen®	
Neocate® Junior - Vanilla	Monogen®	
Neocate® Junior - Unflavored without Prebiotics		
Neocate® Splash Unflavored		
Neocate® Splash - Grape		
Neocate® Splash - Orange Pineapple		
Neocate® Splash - Tropical		

DIAGNOSIS	ICD-10 Codes	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	K90.9
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, <i>with</i> status epilepticus	G40.411
Dermatitis due to ingested food	L27.2	Other generalized epilepsy and epileptic syndromes, intractable, <i>without</i> 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 Failure to thrive (child)	P92.6 R62.51	<5 <sup>th</sup> percentile 5 <sup>th</sup> percentile to <85 <sup>th</sup> percentile	Z68.51* Z68.52*
Gastro-esophageal reflux disease without esophagitis	K21.9	85 <sup>th</sup> percentile to 95 <sup>th</sup> percentile	Z68.53*
Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.311	95 <sup>th</sup> 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 \_\_\_\_\_

I certify that the information provided is accurate to the best of my knowledge. By signing below, I also acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I understand that reimbursement support services are being provided to patients, not DME/Homecare Company, in accord with all laws and regulations and not intended to induce, secure, or reward referrals or use of Nutricia products.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name (Please Print) \_\_\_\_\_ Phone Number \_\_\_\_\_