Nutricia Navigator Patient Information Form

Please Print and Press Firmly
Phone: 800-365-7354

Please Fax Completed Form to: 877-777-0164 or
Email Completed Form to: nutricianavigator@nutricia.com

Service Requested

(Please check all that apply)

	SERVICE		SERVICE		SERVICE
☐	Verify Insurance Benefits	☐	Help with Prior Authorization Denial (please attach)	☐	Other - Please Identify:
☐	Help with Prior Authorization	☐	Help Finding a Supplier		

Attached Documentation

(Please check all that apply)

	DOCUMENTATION		DOCUMENTATION		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 Name _____ Middle Initial _____ Sex _____ Date of Birth _____ Weight (kg) _____

Street Address _____ City _____ State _____ Zip Code _____ Home Number _____ Cell Number _____

Name of Patient Representative to Contact if Necessary _____ Phone Number _____

Email Address _____

Health Insurance Information

(Please complete both Benefit sections or provide front and back of insurance card)

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
Employer Name			

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 _____ Date Signed _____

Patient Medical Information

Patient Name _____

(Please check all that apply)

	PRODUCT		PRODUCT
☐	Neocate® Syneo® Infant	☐	Neocate® Splash - Unflavored
☐	Neocate® Infant DHA/ARA	☐	Neocate® Splash - Grape
☐	Neocate® Nutra	☐	Neocate® Splash - Orange-Pineapple
☐	Neocate® Junior- Unflavored with Prebiotics	☐	DuoCal®
☐	Neocate® Junior- Chocolate	☐	Liquigen®
☐	Neocate® Junior- Tropical	☐	Complete Amino Acid Mix
☐	Neocate® Junior - Strawberry	☐	Phlexy-Vits
☐	Neocate® Junior - Vanilla		
☐	Neocate® Junior - Unflavored without Prebiotics		

	DIAGNOSIS	ICD-10 Code		DIAGNOSIS	ICD-10 Code
☐	Allergic rhinitis due to food allergy	J30.5	☐	Food protein-induced enterocolitis syndrome	K52.21
☐	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	K90.49
☐	Allergy to other foods	Z91.018*	☐	Melena (bloody stools)	K92.1
☐	Other non-medicinal substance allergy status	Z91.048*	☐	Other intestinal malabsorption	K90.89
☐	Dermatitis due to ingested food	L27.2	☐	Postsurgical malabsorption, not elsewhere classified	K91.2
☐	Eosinophilic colitis	K52.82	☐	Underweight	R63.6
☐	Eosinophilic esophagitis	K20.0	☐	<5th percentile 5th percentile to <85th percentile	Z68.51* Z68.52*
☐	Eosinophilic gastritis or gastroenteritis	K52.81	☐	85th percentile to 95th percentile	Z68.53*
☐	Failure to thrive in newborn Failure to thrive (child)	P92.6 R62.51	☐	95th percentile for age	Z68.54*
☐	Gastro-esophageal reflux disease without esophagitis	K21.9	☐	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.

Healthcare Professional Signature _____ Date _____

Healthcare Professional Name (Please Print) _____ Phone Number _____