NUTRICIA
Advanced Medical Nutrition

NUTRICIA NAVIGATOR

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 ______ 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)

MEDICAL BENEFIT

Company Name ______
Telephone ______
Subscriber Name ______
Relation to Patient ______
Social Security ______ Date of Birth ______
Policy ID ______ Group ______
Employer Name ______

PRESCRIPTION DRUG BENEFIT

______
______
______
______
______ Date of Birth ______
______ 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 ______ Date Signed ______

Patient Medical Information

Patient Name ______________________________

(Please check all that apply)

	PRODUCT		PRODUCT		PRODUCT
	Neocate® Syneo® Infant		KetoCal® 2.5:1 Liquid - Vanilla		Complete Amino Acid Mix
	Neocate® Infant DHA/ARA		KetoCal® 3:1 Powder		
			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 Code		DIAGNOSIS	ICD-10 Code
	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	K90.49
	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, ***with*** status epilepticus	G40.411
	Dermatitis due to ingested food	L27.2		Other generalized epilepsy and epileptic syndromes, intractable, ***without*** 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		<5th percentile 5th percentile to <85th percentile	Z68.51* Z68.52*
	Gastro-esophageal reflux disease without esophagitis	K21.9		85th percentile to 95th percentile	Z68.53*
	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.311		95th 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 physician or prescriber, 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 ______________________