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

(Please check all that apply)

Service Requested

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

(Please check all that apply)

Attached Documentation

	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 _____

Metabolic Formula

Primary Formula _____ Type (powder, liquid) _____ Form (can, sachet) _____ Flavor _____

Secondary Formula _____ Type (powder, liquid) _____ Form (can, sachet) _____ Flavor _____

Previous Formula _____

KetoCal & Other Nutritionals

(Please check all that apply)

	PRODUCT		PRODUCT		PRODUCT
☐	KetoCal® 2.5:1 LQ Vanilla	☐	Duocal®	☐	Complete Amino Acid Mix
☐	KetoCal® 3:1 Powder	☐	Liquigen®	☐	Essential Amino Acid Mix
☐	KetoCal® 4:1 LQ Unflavored	☐	Polycal™	☐	Phlexy-Vits
☐	KetoCal® 4:1 LQ Vanilla				
☐	KetoCal® 4:1 Powder				

Tube Fed ☐ Yes ☐ No

Amount Per Day: grams/mL _____ Calorie Requirement Per Day _____

	DIAGNOSIS	ICD-10 Code		DIAGNOSIS	ICD-10 Code
☐	Classical phenylketonuria	E70.0	☐	Argininosuccinic aciduria	E72.22
☐	Other hyperphenylalaninemias	E70.1	☐	Citrullinemia	E72.23
☐	Tyrosinemia	E70.21	☐	Other disorders of urea cycle metabolism	E72.29
☐	Maple syrup urine disease	E71.0	☐	Disorders of ornithine metabolism (includes Ornithine transcarbamylase deficiency)	E72.4
☐	Isovaleric acidemia	E71.110	☐	Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.311
☐	Methylmalonic acidemia	E71.120	☐	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus	G40.319
☐	Propionic acidemia	E71.121	☐	Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus	G40.411
☐	Long chain/very long chain acyl CoA dehydrogenase deficiency	E71.310	☐	Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus	G40.419
☐	Homocystinuria	E72.11	☐	Other, please list:	
☐	Disorders of lysine and hydroxylysine metabolism (includes Glutaric aciduria type 1)	E72.3			
☐	Argininemia	E72.21			

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 _____