NUTRICIA NAVIGATOR PROGRAM INFORMATION FORM

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

All Fields Required. Please send completed form to:
Fax: 833-869-0554 or **Email:** NutriciaNavigator@Nutricia.com

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____ Sex: _____

Date of Birth (MM/DD/YYYY): _____ Street Address: _____

City: _____ State: _____ Zip _____ Home Phone: _____ Cell Phone: _____

Authorized Patient Representative: _____ Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION Please fill this section out completely, or provide a copy (front and back) of insurance card

Primary Medical Insurance: _____ Phone: _____

Cardholder Name: _____ Relationship to Cardholder: _____

Policy Number: _____ Group Number: _____

Primary Prescription Insurance: _____ Card Bin: _____ Phone: _____

Cardholder Name: _____ Relationship to Cardholder: _____

Policy Number: _____ Group Number: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Practice Name: _____ Site Contact: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Fax: _____

Tax ID: _____ NPI: _____ PTAN: _____

Prescriber Specialty: _____ Preferred DME Provider: _____

PRESCRIPTION INFORMATION

Primary Product Name: _____ Type (powder, liquid): _____ Form can, pouch: _____

Secondary Product Name (if applicable): _____ Type (powder, liquid): _____ Form can, pouch: _____

Diagnosis: _____ Tube Fed: ☐ Yes ☐ No

Amount Needed per Day (check one): ☐ _____ calories ☐ _____ grams ☐ _____ fl oz ☐ _____ can(s)/pouch(es)

☐ _____ case(s) ☐ _____ tablets _____ % of Daily Caloric Intake Needs

I certify that the above nutrition therapy information is medically necessary for this patient. I authorize the Nutricia Navigator to act on my behalf for the limited purposes of transmitting the above prescription by any means under applicable law to the appropriate pharmacy/DME(s) designated by me, the patient, or the patient's plan. Prescriber attests this is his/her legal signature.

Prescriber Signature: _____ Date: _____

SERVICES REQUESTED

☐ Verify Insurance Benefits ☐ Help Finding a Supplier ☐ Help with Prior Authorization

☐ Other - Please Identify: _____

Please include any additional information as required, including but not limited to: growth charts, prior authorization requests/denials, prescription, lab results, officenotes, letter of medical necessity, etc.

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: 45610 Woodland Road, Suite 320, Sterling, VA 20166. (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 rightto receive a copy of this form from Nutricia.

OPTIONAL: Please check those that apply.

☐ Consent to Income Verification for the Nutricia Patient Assistance Program Qualification: if I am seeking or eligible for financial assistance into the Patient Assistance Program, Nutricia has my permission to obtain credit reports about me from credit reporting agencies to estimate my income for determination of my eligibility for financial assistance through the program. Regardless of whether a credit report is obtained, Nutricia has the right to require written proof of income (ie, Form 1040, W-2, or other documents) in connection with a financial eligibility determination both prior to acceptance into the Nutricia Patient Assistance Program or during my enrollment in the program.

☐ Consent to Marketing: I give my permission to allow Nutricia to provide me with information about Nutricia products, disease education and awareness and management programs, and promotional materials related to my condition or treatment.

Patient Signature (if 18 or over) or Patient's Representative: _____ Date: _____

Relationship to Patient: _____

Questions? Please call 800-365-7354,
Monday-Friday 9am-6pm ET

Form submitted by:
☐ HCP Office ☐ Patient ☐ DME

Contact Name: _____ Contact Number: _____

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