



REQUEST FOR ENTERAL FORMULA
(From Medicaid)



PART 1: WIC PROGRAM *(completed by WIC Nutritionist)*

Children under 5 years, pregnant, breastfeeding, and postpartum women registered with the Women, Infants, and Children (WIC) Program.

Recipient Name: _____ **Birth Date:** _____

This is to verify that the Florida WIC Program has provided the maximum amount of the requested enteral formula(s) to the above participant as allowable under Federal Regulations. The maximum amount changes based on age for children under age one year. It is deemed that this is an appropriate enteral formula(s) based on the diagnosis and patient counseling. If no formula is provided by the WIC program, the nutritionist must state the reason why below.

Formula name and amount per month provided by WIC: _____

WIC Nutritionist's Signature and Credentials

Phone Number

Date

For additional formula needs, the healthcare provider may complete Part 2 below or provide a prescription in an alternative format to the recipient or directly to a DME provider.*

PART 2: HEALTH CARE PROVIDER'S CERTIFICATION STATEMENT *(completed by the recipient's Health Care Provider)*

Recipient Name: Age: Date of Birth: Qualifying diagnosis: Diagnosis Code (ICD-10):	Name of enteral formula ordered:	Height:	Weight:
	Total # Calories per day from enteral formula: _____	Date measured:	Date measured:
	Formula constitutes _____% of recipients' daily nutrition	BMI:	
	<input type="checkbox"/> Administer by tube <input type="checkbox"/> Administer orally	Projected length of therapy:	

Health Care Provider (Print): _____ License #: _____ Medicaid ID #: _____ NPI # _____

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

Signature of treating Health Care Provider: _____ Phone Number: () _____ - _____ Date: _____

Additional Information For Caregiver And Health Care Provider

Note: Form completion is not a confirmation of Medicaid approval.

*The durable medical equipment (DME) provider may request additional information from the ordering physician, such as but not limited to, a demographic sheet and chart notes which include signs, symptoms, and diagnosis. Insurance/Medicaid information should be provided to the DME provider by the caregiver or healthcare provider. Not all DME providers supply formulas and/or accept Medicaid as a source of payment. The DME provider is responsible for submitting the required information as determined by Florida Medicaid for authorization and payment.

Contact the DME provider of your choice to verify availability of the specific formula(s) needed and what documentation is required by that DME provider. Provide all necessary information to the DME provider, as requested, along with this form.