formula 4 success®

Enrollment is easy—complete both sides of this form, sign and return to the Formula4success® reimbursement specialist at support@nestle4success.com or fax 855-727-2513. For assistance call 1-800-283-0365.

Patient Information

Patient Name: _____ Street Address: _____

Patient Representative: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Phone: _____ eMail: _____

Date of Birth: _____ Known Allergies: _____

Insurance Information

Complete or Attach Copies of Both Sides of Patient Insurance Card(s)

Primary Insurance Company: _____ Secondary Insurance Company: _____

Primary Insurance Phone Number: _____ Secondary Insurance Phone Number: _____

Policy Holder Name: _____ Policy Holder Name: _____

Relation to Patient: _____ Relation to Patient: _____

Policy Holder ID: _____ Policy Holder ID: _____

Group Number: _____ Group Number: _____

Diagnosis

List of Common Diagnoses, May Not Be All Inclusive

- ☐ Intestinal Malabsorption, Unspecified
- ☐ Allergy to Milk Products (CMPA)
- ☐ Lactose Intolerance, Unspecified
- ☐ Eosinophilic Esophagitis
- ☐ Food Protein-Induced Enterocolitis Syndrome
- ☐ Dermatitis due to Ingested Food
- ☐ Feeding Difficulties
- ☐ Allergy to Other Foods (Multiple Food Allergies)
- ☐ Allergic and Dietetic Gastroenteritis and Colitis
- ☐ Eosinophilic Gastritis or Gastroenteritis
- ☐ Gastroesophageal-Reflux Disease with Esophagitis
- ☐ Other: _____

Prescriber Information

Prescriber Name: _____ Phone: _____ Fax: _____

NPI Number: _____ Address: _____

Tax ID: _____ RD Name: _____

Date: _____ RD Phone: _____ RD eMail: _____

Product Recommendation

Extensive HA® ☐ Extensive HA®

Prescription

Feeding Tube Type: PEG/GT ☐ J-Tube ☐ G-J Tube ☐ NG Tube ☐ ND/NJ Tube ☐ None ☐ Other _____

Method of Administration: Pump ☐ Gravity ☐ Bolus ☐ PO ☐ calories/day _____ calories/ounce _____

Bolus Feeding: _____ each _____ times per day

Gravity Feeding: _____ mL _____ times per day

Pump Feeding: administration rate _____ mL/hour for _____ hours per day

Oral Feeding: _____ mL _____ times per day

Dispense: _____ eaches per month and refill _____ times HCPCS Code: B4161

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Preferred Home Enteral Supplier

Name of Supplier: _____ Phone Number: _____

Patient Authorization to Share Medical Information

Required for Patient Enrollment

By signing below and submitting your information, you authorize Formula4Success for Nestlé Healthcare Nutrition, Inc. ("Nestlé"), to contact you and to collect your personal medical and insurance coverage information and share it with our agents and contractors as well as outside organizations (including healthcare providers and health plans), in order to verify insurance coverage and provide you with reimbursement support for Nestlé products. You acknowledge that Nestlé does not guarantee coverage by any insurance plan providers and will not reimburse any claims denied by third party providers. If you want to revoke your consent to access and share your information, you may notify us at any time via email at support@Nestle4success.com.

Patient Name (Print): _____ Date: _____

Patient or Representative Signature (required): _____

(If signed by a representative please explain authority to act for the patient)

Patient Representative (Print): _____

Authority: ☐ Parent/Legal Guardian ☐ Power of Attorney ☐ Limited Power of Attorney

☐ Other (Please Explain) _____

Healthcare Provider Certification

By signing below, I certify that I am the patient's provider. I certify that the information I have provided in this form is accurate to the best of my knowledge. I have determined that the product I have recommended for the patient is medically appropriate, and I certify that my decision to recommend the product was based solely on my determination of medical necessity.

Patient's Name : _____ Date of Birth: _____

Prescriber Signature: _____ Date: _____

Prescriber Name: _____

All medical necessity determinations must be made by the responsible healthcare provider. Each healthcare provider is ultimately responsible for verifying the accuracy of codes, coverage, and payment policies. Contact the appropriate payer(s) for specific questions regarding coding, coverage, or reimbursement. Nestlé does not guarantee reimbursement by any insurance plan and will not reimburse any claims denied by third-party payers.