



EleCare EleCare Jr PATHWAY PRESCRIPTION FORM FOR ELECARE® AND ELECARE® JR\*

1 PATIENT INFORMATION

Patient Name Date of Birth
Parent/Guardian Name Relationship to Patient
Street Address City/State/Zip
Cell Phone # Home/Work # Email
Gender Male Female Primary Language

2 INSURANCE INFORMATION (COMPLETE SECTION OR ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD)

Primary Insurance Company Secondary Insurance Company
Primary Insurance Company Phone # Secondary Insurance Company Phone #
Subscriber Name Subscriber Name
Subscriber ID # Subscriber ID #
Subscriber Date of Birth Subscriber Date of Birth
BIN# PCN# BIN# PCN#
Policy/Employer/Group # Policy/Employer/Group #
Relationship to Subscriber Relationship to Subscriber

3 DIAGNOSIS (The list of diagnoses contained in this form is not all-inclusive.)

REQUIRED: Please indicate ICD-10 code(s)

- Z91.011 Allergy to milk products
E73.8 Other lactose intolerance
E73.9 Lactose intolerance, unspecified
K31.89 Other diseases of stomach and duodenum
K92.1 Melena
K52.21 Food protein-induced enterocolitis syndrome
K20.0 Eosinophilic Esophagitis
L27.2 Dermatitis due to ingested food
Z91.018 Allergy to other foods
K52.81 Eosinophilic gastritis or gastroenteritis
R63.3 Feeding difficulties
Other
K21.9 Gastro-esophageal reflux disease w/o esophagitis
K90.49 Malabsorption due to intolerance, not elsewhere classified
K52.29 Other allergic and dietetic gastroenteritis and colitis
K52.2 Allergic and dietetic gastroenteritis and colitis
K21.0 Gastro-esophageal reflux disease with esophagitis

4 RECOMMENDED PRODUCT

Powder Formula: EleCare Infant EleCare Jr Unflavored EleCare Jr Vanilla EleCare Jr Chocolate EleCare Jr Banana

5 DOSAGE INFORMATION

Based on my patient's current medical condition, I am prescribing Calories /day fl oz/mL /day at Calories /fl oz
with refills for oral or tube feeding. Day Supply Refills Length of Need

6 PRESCRIBER INFORMATION

I certify that the above therapy is medically necessary and 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 to an authorized supplier. I certify that my decision to prescribe EleCare and EleCare Jr was based solely on my determination of medical necessity set forth herein.

Signature Date
Prescriber Name Physician Provider NPI #/Tax ID #
Phone # Physician Provider Medicaid ID #
Name of Contact Person Contact Phone # Fax #
Facility Name Preferred Contact Method: Phone Fax
Facility Address City/State/Zip

7 SPECIAL INSTRUCTIONS

Preferred DME or Pharmacy Supplier

\* Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided. Providers should consult with the insurance plan for complete and accurate details concerning documentation for claims. Abbott Nutrition does not guarantee reimbursement by any third-party insurance plan and will not reimburse physicians or providers for claims denied by third-party insurance plans.



# AUTHORIZATION TO SHARE MEDICAL INFORMATION

Prescriber OR Patient may sign this certification

## Prescriber Certification Statement

By signing below, I hereby attest that I am the prescribing provider and I agree to submit this request to Abbott Nutrition's Pathway Plus for EleCare Reimbursement Support Program. I have determined that the EleCare/ElleCare Jr product I have recommended is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996) to Pathway Plus for the purpose of providing general reimbursement support and assisting in initiating or continuing therapy.

My signature below indicates that I understand the information provided above and I certify that the patient has provided my office with written consent and authorization to proceed with this research. I understand that if I have not secured consent from my patient to pursue insurance research, Pathway Plus will be unable to proceed with this request. I confirm I have the patient's consent prior to submitting the insurance research requests.

Patient's Name (print) \_\_\_\_\_ DOB \_\_\_\_\_

Provider's Name (print) \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Provider's original signature (no stamped signatures)*

## Patient Certification Statement (required only if the patient is requesting Pathway Plus services)

By signing below, you authorize Pathway Plus for EleCare to access your personal medical and insurance coverage information in order to perform Pathway Plus services. The information that you provide will be held in strict confidence and only be used to conduct this verification and explore potential reimbursement options. We also want to inform you that you can refuse to provide this consent and/or withdraw it at any time but doing so would disable our program from being able to provide these services to you. Do you authorize our program to access your personal medical and insurance coverage information?

Patient's Name (print) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Signature of Patient or Patient Representative  
 (If signed by Representative, explain authority to act for the Patient)*

Patient's Representative's Name (print) \_\_\_\_\_

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

Other (please specify) \_\_\_\_\_

Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided. Providers should consult with the insurance plan for complete and accurate details concerning documentation for claims. Abbott Nutrition does not guarantee reimbursement by any third-party insurance plan and will not reimburse physicians or providers for claims denied by third-party insurance plans.

