pathway

PLEASE SIGN AND FAX THIS FORM TO 1-877-433-8066. FOR QUESTIONS, PLEASE CALL 1-800-558-7677.

Juven® specialized nutrition powder from the makers of Ensure®

PATHWAY SERVICES REQUEST FORM FOR **JUVEN®***

1 SERVICE REQUESTED

Please select which service you are requesting:

○ Benefit Verification ○ Prior Authorization Support ○ Appeals Assistance ○ Claims Support

2 PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Parent/Guardian Name _____ Relationship to Patient _____

Street Address _____ City/State/ZIP _____

Home Phone # _____ Work/Cell Phone # _____ Social Security # _____

Allergies _____ Patient/Caregiver Primary Language _____

Gender ○ Male ○ Female

3 INSURANCE INFORMATION

(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 # _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

4 DIAGNOSIS

REQUIRED: ***Please indicate ICD-9 or ICD-10 code(s) here*** _____

Juven is targeted therapeutic nutrition to help build lean body mass to support healing.

- ○ Human Immunodeficiency Virus (HIV) Disease
- ○ Cancer
- ○ Pressure Ulcer, Unspecified Site
- ○ Pressure Ulcer, Elbow
- ○ Pressure Ulcer, Upper Back
- ○ Pressure Ulcer, Lower Back
- ○ Pressure Ulcer, Hip
- ○ Pressure Ulcer, Buttock
- ○ Pressure Ulcer, Ankle
- ○ Pressure Ulcer, Heel
- ○ Pressure Ulcer, Other Site
- ○ Pressure Ulcer, Unspecified Stage
- ○ Other _____
- ○ Pressure Ulcer, Stage I
- ○ Pressure Ulcer, Stage II
- ○ Pressure Ulcer, Stage III
- ○ Pressure Ulcer, Stage IV
- ○ Pressure Ulcer, Unstageable
- ○ Surgical Incisions

5 RECOMMENDED PRODUCT

○ ***Juven*** Orange .85 oz ○ ***Juven*** Grape .85 oz

6 DOSAGE INFORMATION

Based on my patient's current medical condition, I am prescribing _____ CALORIES and _____ OUNCES/mL per day with refills **for** ○ oral or ○ tube feeding.

7 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. I certify that my decision to prescribe ***Juven*** was based solely on my determination of medical necessity set forth herein.

Prescriber Name _____ Physician Provider/NPI # _____

Phone # _____ Physician Provider/Tax ID # _____

Name of Contact Person _____ Contact Phone # _____ Fax # _____

Street Address _____ City/State/ZIP _____

Prescriber Signature (Required) _____ Date _____

8 SPECIAL INSTRUCTIONS

Preferred Supplier _____ Other _____

*The list of diagnoses contained in this form is not all-inclusive. It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Abbott Nutrition does not guarantee that the use of any information provided in this form will result in coverage or payment by any third-party payer.

Abbott Nutrition

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 Reimbursement Support Program. I have determined that the Abbott Nutrition 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 for the purpose of providing general reimbursement support, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for the Abbott Nutrition Patient Assistance Program.

If applying for the Abbott Nutrition Patient Assistance Program, I certify that this patient has no insurance and is not eligible for other public health insurance programs. I agree to notify the Abbott Nutrition Patient Assistance Program if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status or the indication for which the product has been recommended for this patient. I understand that Abbott Nutrition reserves the right to change or terminate PATHWAY or the Patient Assistance Program any time, or to refuse to provide Abbott Nutrition product under the Abbott Nutrition Patient Assistance Program to any patient.

If my patient obtains an Abbott Nutrition product from the Abbott Nutrition Patient Assistance Program I understand that (a) no third party or patient can be charged for the Abbott Nutrition product provided under such program and (b) that no free product should be sold, traded, or distributed for sale. I also understand that provision of free product as part of the Abbott Nutrition Patient Assistance Program is not contingent upon future purchase or prescribing of Abbott Nutrition products.

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 will be unable to proceed with this request. I confirm I have the patient's consent prior to submitting the insurance research requests.

(Provider's signature required if provider initiates PATHWAY services)

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 services)

By signing below, you authorize PATHWAY to access your personal medical and insurance coverage information in order to perform PATHWAY services. The information that you provide will be held in strict confidence and only be used to conduct this verification and explore potential reimbursement or patient assistance 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.

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