



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, 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 ID #, Subscriber Date of Birth, BIN#, PCN#, Policy/Employer/Group #, 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, E73.9 Lactose intolerance, unspecified, E40 Kwashiorkor, E43 Unspecified severe protein-calorie malnutrition, E44 Protein-calorie malnutrition of moderate and mild degree, K90.0 Celiac Disease, R62.51 Failure to thrive (child), E41 Nutritional marasmus, E46 Unspecified protein-calorie malnutrition, E45 Retarded development following protein-calorie malnutrition, R63.3 Feeding difficulties, R63.4 Abnormal weight loss, R63.6 Underweight, Other

4 RECOMMENDED PRODUCT

PediaSure Harvest

5 DOSAGE INFORMATION

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

6 PROVIDER 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 PediaSure Harvest was based solely on my determination of medical necessity set forth herein.

Signature, Date, Provider 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

Provider OR Patient may sign this certification

Provider 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 Reimbursement Support Program. I have determined that the PediaSure Harvest 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 assessment. I understand that if I have not secured consent from my patient to pursue an insurance assessment, Pathway Plus will be unable to proceed with this request.

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 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) _____

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