PLEASE SIGN AND FAX THIS FORM TO 1-855-752-9885. FOR QUESTIONS, PLEASE CALL 1-855-217-0698

PATHWAY PLUS RECOMMENDATION FORM FOR **SIMILAC® NEOSURE®** INFANT FORMULA **WITH IRON**

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)***

P07.0 - Extremely low birth weight newborn
P07.1 - Other low birth weight newborn
P07.3 - Preterm newborn
R63.3 Feeding difficulties
R63.6 Underweight
F98.29 Other feeding disorders of infancy and early childhood
R62.51 Failure to thrive
Other______________________

4 RECOMMENDED PRODUCT

Similac NeoSure Powder Similac NeoSure Ready to Feed

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 ***Similac NeoSure®*** 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.

Copyright © 2019 Abbott. 20192546/Dec 2019 LITHO IN USA

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 Similac NeoSure® 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 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) ______________________________

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.

Copyright © 2019 Abbott 20192546/Dec 2019 LITHO IN USA

Abbott