



Select Health Plan:

- HealthEase
- WellCare
- Staywell

FOOD SUPPLEMENT REQUEST FORM

Toll Free Fax (866) 825-2884

Children under 5 years of age, pregnant women and postpartum women must first register with the federal program for women, infants and children (WIC). A copy of the WIC statement must be attached to this form.

PHYSICIAN COMPLETE THIS SECTION – REQUIRED INFORMATION

Member ID# _____ DOB ____/____/____

First name _____ M.I. _____ Last Name _____

Prescriber Name _____ Specialty _____

Contact Person _____ Prescriber Phone (____) _____

Prescriber Fax (____) _____

Food supplement requested: _____

QTY _____ Cans/Scoops/Pkts Per Day _____ Length of Therapy _____

Diagnosis _____

Dosage and Frequency of dosing _____ Oral Tube Feeds

Height and Weight (required) _____ ft _____ in _____ lbs Date measured ____/____/____

Comments _____

Consultation with a Registered Dietician? Yes No Date _____ RD Name _____

***** Required Physician Certification Statement *****

“I hereby certify that, without this food supplement, this patient will require institutionalization.”

Signature _____ Date _____

Please attach a copy of the original prescription. Attach lab results and other documentation as necessary.

For Internal Use Only