



PHYSICIAN COMPLETE THIS SECTION - REQUIRED INFORMATION





## FOOD SUPPLEMENT REQUEST FORM- Florida

## Toll Free Fax 1-866-825-2884

Children Under 5 Years, Pregnant 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.

Member ID#	DOB/
First name	M.I Last Name
Prescriber Name	Specialty
Contact Person	Presciber Phone ()
	Prescriber Fax ()
Food supplement requested:	
QTYCans/Scoops/Pkts per Day	Length of Therapy
Diagnosis	
Dosage and Frequency of dosing	Oral □ Tube Feeds
Height and Weight (required):ftir	inlbs Date measured/
Comments	<del></del>
	<del></del>
Consultation with a Registered Dietician? ☐ Yes	es 🗖 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 prescri	ription. Attach lab results and other documentation as necessary.
For Internal Use Only	