Elm Pharmacy 1651 Coney Island Ave; Brooklyn, NY 11230 **718-336-8300** *(fax) 718-336-8421*

FAX

To:	**From:**
Fax:	**Pages:**
Phone:	**Date:**
Re:	**CC:**

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:
For us to do insurance authorizations for nutritionals, we need:

1. **Prescription with amount of calories or number of ounces per day the child is drinking (the authorizations are done for a 6 month period so when you write the prescription keep in mind the growth of the child and prescribe enough calories)**
2. **Letter of medical necessity. (see attached letter)**
3. **Growth chart (if you have it) or height and weights**
4. **Clinical notes**

Thank you *** any questions please call 718-336-8300** **www.elmpharmacy.biz**

Elm Pharmacy

1651 Coney Island Avenue

Brooklyn, NY 11230

718-336-8300

718-336-8421 (fax)

elm_pharmacy@yahoo.com

Elm Pharmacy 1651 Coney Island Ave; Brooklyn, NY 11230 **718-336-8300** *(fax) 718-336-8421*

Dear Sir or Madam:

I am requesting insurance coverage and reimbursement for my patient,___________________________, born on _________ for whom I have prescribed the use of ____________________. **Based on this patient's clinical history, I have determined that this formula is medically necessary.**

My patient's present weight is _____________ and height is _______________. This formula provides complete nutrition and is the *sole source of nutrition* for this patient. **The formula** will be taken orally, however if the patient is unable to consume enough to meet the nutritional requirements for proper growth and development, we may consider alternate feeding methods, such as insertion of a feeding tube. **It** is medically necessary for my patient to receive the prescribed formula.

To date, my patient has *failed* these formulas

____.

My patient has been diagnosed with one or more of the following:

Diagnosis	ICD – 10 Code
☐ bloody stool(s)	K92.1
☐ allergic gastroenteritis and colitis	K52.2
☐ atopic dermatitis due to food allergy	L27.2
☐ allergic rhinitis due to food allergy	J30.5
☐ gastroesophageal reflux disease	K21.9
☐ malabsorption	K90.9
☐ short bowel syndrome	K91.2
☐ failure to thrive (newborn)	P92.6
☐ failure to thrive (non-newborn)	R62.51
☐ eosinophilic esophagitis	K20.0
☐ eosinophilic gastritis or gastroenteritis	K52.81
☐ eosinophilic colitis	K52.82
☐ underweight	R63.6
☐ Allergy to milk products	Z91.011
☐ Allergy to other food	Z91.018
☐ Other non-medicinal substance allergy	Z91.048

This patient's clinical nutritional status will be monitored by the physician

Your approval of this request for assistance with medical care and reimbursement of the formula would have a significant positive impact on this patient's health.

Sincerely,

____

Signature

____

Name

____

Date

Patient referral authorization form

Patient name: ______________________________

DOB (mm-dd-yyyy)**:** ______________________ **TRICARE ID:** ______________

Sponsor address: ______________________________

Other Health Insurance: ☐ Yes ☐ No **Carrier:** ______________________

Policy # ______________________ **Phone:** ______________

Provider or setting: ☐ Physician's office ☐ Allied health professional's office ☐ Outpatient facility ☐ Inpatient facility

Date of service (if known; mm-dd-yyyy)**:** ______________ ☐ Evaluate only ☐ Evaluate and treat

Point of contact: ______________________________

Ordering provider: ______________________ **Phone:** ______________

Type of service: ☐ Office visit **List specialty:** ______________ **Specialist Tax ID/NPI:** ______________

☐ Surgical/Diagnostic procedure ☐ Speech therapy ☐ Hospice ☐ Home health ☐ DME ☐ Observation ☐ PT/OT

☐ OP behavioral health ☐ Other ☐ Inpatient admission: ☐ Acute care ☐ Rehab ☐ SNF

If inpatient, please provide a diagnosis code: ______________________

Procedure or HCPC code: ______________________

Facility: ______________________ **Tax ID/NPI:** ______________

Address: ______________________________

Rendering provider: ______________________ **Tax ID/NPI:** ______________

Address: ______________________________

Presenting symptoms or reason for referral: ______________________

____

Pertinent history, findings and specials situations include known discharge needs if inpatient admission: ______________

____

____

TRICARE referrals should be submitted through HumanaMilitary.com/ProvSelfService. If you do not have internet connection in your office, you may complete and submit this form by fax to 1-877-548-1547. The military hospital or clinic in your area may have Right of First Refusal for this service.

(01/2018)