



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

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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:

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