



Enrollment is easy—complete both sides of this form, sign and return to the Formula4success® reimbursement specialist at support@nestle4success.com or fax 855-727-2513. For assistance call 1-844-283-0365.

Patient Information

Patient Name: Street Address:
Patient Representative: City: State: Zip:
Relationship to Patient: Phone: eMail:
Date of Birth: Known Allergies:

Insurance Information

Complete or Attach Copies of Both Sides of Patient Insurance Card(s)

Primary Insurance Company: Secondary Insurance Company:
Primary Insurance Phone Number: Secondary Insurance Phone Number:
Policy Holder Name: Policy Holder Name:
Relation to Patient: Relation to Patient:
Policy Holder ID: Policy Holder ID:
Group Number: Group Number:

Diagnosis

List of Common Diagnoses, May Not Be All Inclusive

- Intestinal Malabsorption, Unspecified
Allergy to Milk Products (CMPA)
Lactose Intolerance, Unspecified
Eosinophilic Esophagitis
Food Protein-Induced Enterocolitis Syndrome
Dermatitis due to Ingested Food
Feeding Difficulties
Allergy to Other Foods (Multiple Food Allergies)
Allergic and Dietetic Gastroenteritis and Colitis
Eosinophilic Gastritis or Gastroenteritis
Gastroesophageal-Reflux Disease with Esophagitis
Other:

Prescriber Information

Prescriber Name: Phone: Fax:
NPI Number: Address:
Tax ID: RD Name:
Date: RD Phone: RD eMail:

Product Recommendation

Alfamino. [ ] Alfamino® Infant [ ] Alfamino® Junior, Unflavored [ ] Alfamino® Junior, Vanilla

Prescription

Feeding Tube Type: PEG/GT [ ] J-Tube [ ] G-J Tube [ ] NG Tube [ ] ND/NJ Tube [ ] None [ ] Other
Method of Administration: Pump [ ] Gravity [ ] Bolus [ ] PO [ ] calories/day calories/ounce
Bolus Feeding: each times per day
Gravity Feeding: mL times per day
Pump Feeding: administration rate mL/hour for hours per day
Oral Feeding: mL times per day
Dispense: eaches per month and refill times HCPCS Code: B4161

Medical necessity determinations must be made by the responsible healthcare provider. Each healthcare provider is ultimately responsible for verifying the accuracy of codes, coverage, and payment policies. Contact the appropriate payer(s) for specific questions regarding coding, coverage, or reimbursement. Nestlé does not guarantee reimbursement by any insurance plan and will not reimburse any claims denied by third-party payers.



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Preferred Home Enteral Supplier

Name of Supplier: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Authorization to Share Medical Information

Required for Patient Enrollment

By signing below and submitting your information, you authorize Formula4Success for Nestlé Healthcare Nutrition, Inc. (“Nestlé”), to contact you and to collect your personal medical and insurance coverage information and share it with our agents and contractors as well as outside organizations (including healthcare providers and health plans), in order to verify insurance coverage and provide you with reimbursement support for Nestlé products. You acknowledge that Nestlé does not guarantee coverage by any insurance plan providers and will not reimburse any claims denied by third party providers. If you want to revoke your consent to access and share your information, you may notify us at any time via email at [support@Nestle4success.com](mailto:support@Nestle4success.com).

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Representative Signature (required): \_\_\_\_\_

(If signed by a representative please explain authority to act for the patient)

Patient Representative (Print): \_\_\_\_\_

Authority:  Parent/Legal Guardian  Power of Attorney  Limited Power of Attorney  
 Other (Please Explain) \_\_\_\_\_

Healthcare Provider Certification

By signing below, I certify that I am the patient’s provider. I certify that the information I have provided in this form is accurate to the best of my knowledge. I have determined that the product I have recommended for the patient is medically appropriate, and I certify that my decision to recommend the product was based solely on my determination of medical necessity.

Patient’s Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

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