



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*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Malabsorptive Syndrome/<br>Gastrointestinal Intolerance  | <input type="checkbox"/> Cerebral Palsy, Unspecified                | <input type="checkbox"/> Chronic Pancreatitis  |
| <input type="checkbox"/> Intestinal Malabsorption, Unspecified                    | <input type="checkbox"/> IBD: Crohn's Disease or Ulcerative Colitis | <input type="checkbox"/> Liver Transplant Status                                       |
| <input type="checkbox"/> Post-Surgical Malabsorption,<br>Not Elsewhere Classified | <input type="checkbox"/> Cystic Fibrosis, Unspecified               | <input type="checkbox"/> Non-Infectious<br>Gastroenteritis and Colitis,<br>Unspecified |
|   | <input type="checkbox"/> Underweight/Growth Failure/Malnutrition    | <input type="checkbox"/> Other: _____  |
|   | <input type="checkbox"/> Acute Pancreatitis, Unspecified            |  |

### Prescriber Information

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

### Product Recommendation

Peptamen Junior®  Peptamen Junior® PHGG  Peptamen Junior® HP  Peptamen Junior® Prebio  Peptamen Junior® 1.5

### 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 per day: \_\_\_\_\_  
 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.

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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