



New Hampshire WIC Nutrition and Medicaid Program Request for Special Formula and Authorization for WIC Supplemental Foods

For dually enrolled participants on WIC and Medicaid, NH Medicaid/Managed Care Organization (MCO) determines and provides special formulas. Healthcare providers should work directly with the participant's MCO for the requirements/additional forms/prior authorization for the provision of special formulas. Because WIC may need to provide the special formula prescribed temporarily a completed WIC Request for Special Formula form is needed. **Request for Special formula are subject to WIC approval. The continued need for a special formula will be re-evaluated on a periodic basis.**

Return to WIC agency: _____ **Fax #:** _____

A. Patient/participant information

Patient's Name: (Last, First, MI): _____ **DOB:** _____

Parent/Caregiver's Name: _____ **Medicaid #:** _____

Medical Diagnosis & ICD code(s):

<input type="checkbox"/> Allergy, Food: _____ (K52.5)	<input type="checkbox"/> Diabetes Mellitus Type I (E10)	<input type="checkbox"/> Lactose Intolerance (E73)
<input type="checkbox"/> Autoimmune Disorder (M35.9)	<input type="checkbox"/> Diseases of the Digestive System (K00-K95); specify: _____	<input type="checkbox"/> Malnutrition (E43)
<input type="checkbox"/> Anomaly, Respiratory (Q34.9)	<input type="checkbox"/> Endocrine, Nutritional & Metabolic Diseases, and Immunity Disorders (E00-E89); specify: _____	<input type="checkbox"/> Neonatal Abstinence Syndrome (P96.1)
<input type="checkbox"/> Anomaly, GI (Q45.9)	<input type="checkbox"/> FTT/Inadequate Growth (R62.51)	<input type="checkbox"/> Neuromuscular Disorder (G70.9)
<input type="checkbox"/> Conditions Originating in the Perinatal Period (P00-P96); specify: _____	<input type="checkbox"/> Immunodeficiency (D80-D84)	<input type="checkbox"/> Pregnancy, Multiple Gestation (O30)
<input type="checkbox"/> Congenital Heart Disease (Q24.9)		<input type="checkbox"/> Prematurity (P07.3)
<input type="checkbox"/> Delay, Developmental (R62.0)		<input type="checkbox"/> Other: specify nutrition-related condition and ICD code: _____

B. Special formula *(Approved NH WIC formulary can be viewed at www.dhhs.nh.gov/dphs/nhp/wic/physician.htm)*

Formula requested: _____

Prescribed amount: maximum allowable by WIC* **OR** _____ oz./day

* WIC Federal regulations allow: Infants 0-3months ~28oz/day; 4-5months ~30oz/day; 6-12months ~22oz/day. Children/Women: ~30oz/day.

Time needed: 1 month 3 months 6 months 12 months _____ months (Not to exceed 12 months.)

C. WIC supplemental foods

I authorize the NH WIC nutritionist to determine appropriate WIC supplemental foods, amounts, and length of issuance required for the participant.

I do not agree with the statement above, issue a modified food package omitting the WIC foods checked below.

<input type="checkbox"/> Infant cereal	<input type="checkbox"/> Infant fruits	<input type="checkbox"/> Infant vegetables	<input type="checkbox"/> Infant meats-(exclusively breastfeed infants only)
<input type="checkbox"/> Milk/cheese/yogurt	<input type="checkbox"/> Soymilk/tofu	<input type="checkbox"/> Eggs	<input type="checkbox"/> Fruits <input type="checkbox"/> Juice <input type="checkbox"/> Vegetables
<input type="checkbox"/> Breakfast cereals	<input type="checkbox"/> Whole grains-bread/rice/tortillas/oatmeal/pasta		
<input type="checkbox"/> Beans/peas/lentils	<input type="checkbox"/> Peanut butter	<input type="checkbox"/> Fish-(exclusively breastfeeding women only)	<input type="checkbox"/> OMIT ALL Foods

D. Healthcare provider information

Medical documentation is federally required to ensure that the patient under your care has a medical condition that requires the use of special formula and that WIC foods are precluded, restricted, or inadequate to meet their special nutritional needs. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining he/she has a serious medical condition.

Signature of healthcare provider: _____ **Date:** _____

Provider's name: (please print or stamp) _____ MD DO NP PA

Medical office/clinic: _____

Phone #: _____ **Fax#:** _____

E. Release of information

I authorize the above healthcare provider and NH WIC staff to disclose/discuss information regarding this request. I understand that I may change my mind and cancel this permission at any time with my written request to my healthcare provider and that it will not affect my WIC eligibility.

Participant/Parent/Caregiver Signature: _____ Printed Name: _____ Date: _____

WIC USE ONLY: Approved by: _____ Date: _____