Request for Medicaid Formula/Medical Nutritional Products

Dear Vendor-This WIC/Medicaid recipient:

( ) was provided with the maximum amount of________________________________
allowed under the WIC program; however, due to his/her medical condition he/she needs
_______additional cans per month for ________________months.

( )was prescribed a medical nutritional product (e.g., Polycose, MCT oil, Duocal, pudding) per Doctor's orders, in addition to the formula given by WIC. Wic cannot provide this product due to maximum issuance limits.

( )will no longer be eligible for WIC benefits on his/her 5th birthday.

The participant is requesting that Medicaid provide the additional formula/medical nutritional product. The participant's information is as follows:

Name________________________________DOB_________Medicaid #____________
(Last) (First) (MI)

Address____
(Street) (City) (State) (Zip)

Parent/Guardian's name____

Physician________________________________Phone_____________________

Medical Diagnosis____
Current Height__________Weight____________Date__________________________
Name of formula/nutritional product____
Amount requested (Medicaid only) per month__________________________________
Daily calorie intake______________ % of daily intake from formula/medical nutritional______
Length of time needed____
Has this person seen a dietician? Yes_______ No_______
Is this child fed by gastrostomy tube? Yes_______ No_______

(Please attach):
Explain why this child cannot be maintained on an age-appropriate diet and attach any additional explanation to support medical necessity. Be specific.
List other formulas which have been tried and why they did not meet client's needs.
Attach growth chart showing growth history.

To the parent/guardian: I give my permission for WIC to share this information with the Medicaid vendor and/or my child's physician/health care provider for the purpose of obtaining the formula or medical nutritional product that my child needs.

____
Signature Date Print name

Local WIC Agency phone number______________________________
Contact person____
(This form was developed by the State WIC office, Texas Dept. of Health)