pathway plus

Similac® ALIMENTUM®

PLEASE SIGN AND FAX THIS FORM TO 1-855-752-9885. FOR QUESTIONS, PLEASE CALL 1-855-217-0698

PATHWAY PLUS RECOMMENDATION FORM FOR **SIMILAC ALIMENTUM®***

1 PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Parent/Guardian Name _____ Relationship to Patient _____

Street Address _____ City/State/Zip _____

Cell Phone # _____ Home/Work # _____ Email _____

Gender ☐ Male ☐ Female Primary Language _____

2 INSURANCE INFORMATION

(COMPLETE SECTION OR ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD)

Primary Insurance Company _____ Secondary Insurance Company _____

Primary Insurance Company Phone # _____ Secondary Insurance Company Phone # _____

Subscriber Name _____ Subscriber Name _____

Subscriber ID # _____ Subscriber ID # _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

BIN# _____ PCN# _____ BIN# _____ PCN# _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

Relationship to Subscriber _____ Relationship to Subscriber _____

3 DIAGNOSIS **(The list of diagnoses contained in this form is not all-inclusive.)**

REQUIRED: ***Please indicate ICD-10 code(s)***

- ☐ Z91.011 Allergy to milk products
- ☐ Z91.018 Allergy to other foods
- ☐ Other _____
- ☐ L27.2 Dermatitis due to ingested food
- ☐ E73.9 Lactose intolerance, unspecified
- ☐ Other _____
- ☐ K52.21 Food protein-induced enterocolitis syndrome
- ☐ K52.2 Allergic and dietetic gastroenteritis and colitis
- ☐ K90.49 Malabsorption due to intolerance, not elsewhere classified

4 RECOMMENDED PRODUCT

☐ Similac Alimentum – Powder ☐ Similac Alimentum – Liquid

5 DOSAGE INFORMATION

Based on my patient's current medical condition, I am recommending _____ Calories /day _____ fl oz/mL /day at _____ Calories /fl oz

with refills for ☐ oral or ☐ tube feeding. Day Supply _____ Refills _____ Length of Need _____

6 PROVIDER INFORMATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I also acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed to an authorized supplier. I certify that my decision to prescribe ***Similac Alimentum*** was based solely on my determination of medical necessity set forth herein.

Signature _____ Date _____

Provider Name _____ Physician Provider NPI #/Tax ID # _____

Phone # _____ Physician Provider Medicaid ID # _____

Name of Contact Person _____ Contact Phone # _____ Fax # _____

Facility Name _____ Preferred Contact Method: ☐ Phone ☐ Fax

Facility Address _____ City/State/Zip _____

7 SPECIAL INSTRUCTIONS

Preferred DME or Pharmacy Supplier _____

* Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided. Providers should consult with the insurance plan for complete and accurate details concerning documentation for claims. Abbott Nutrition does not guarantee reimbursement by any third-party insurance plan and will not reimburse physicians or providers for claims denied by third-party insurance plans.

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AUTHORIZATION TO SHARE MEDICAL INFORMATION

Provider OR Patient may sign this certification

Provider Certification Statement

By signing below, I hereby attest that I am the prescribing provider and I agree to submit this request to Abbott Nutrition's Pathway Plus Reimbursement Support Program. I have determined that the Similac Alimentum product I have recommended is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996) to Pathway Plus for the purpose of providing general reimbursement support and assisting in initiating or continuing therapy.

My signature below indicates that I understand the information provided above and I certify that the patient has provided my office with written consent and authorization to proceed with this assessment. I understand that if I have not secured consent from my patient to pursue insurance assessment, Pathway Plus will be unable to proceed with this request.

Patient's Name (print)_____ DOB _____

Provider's Name (print) _____

Provider's Signature_____ Date _____

Provider's original signature (no stamped signatures)

Patient Certification Statement (required only if the patient is requesting Pathway Plus services)

By signing below, you authorize Pathway Plus to access your personal medical and insurance coverage information in order to perform Pathway Plus services. The information that you provide will be held in strict confidence and only be used to conduct this verification and explore potential reimbursement options. We also want to inform you that you can refuse to provide this consent and/or withdraw it at any time but doing so would disable our program from being able to provide these services to you. Do you authorize our program to access your personal, medical, and insurance coverage information?

Patient's Name (print) _____

Patient's Signature_____ Date _____

Signature of Patient or Patient Representative
(If signed by Representative, explain authority to act for the Patient)

Patient's Representative's Name (print) _____

Authority: ☐ Parent/Legal Guardian ☐ Power of Attorney ☐ Limited Power of Attorney

☐ Other (please specify) _____

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