THE OHIO STATE UNIVERSITY
HEALTH PLAN

Pediatric and Adult Formula Request Form

Submit completed form and supporting documentation to UtilizationManagement.OSUHealthPlan@OSUMC.edu or fax to 614-292-2667

General Information		
Covered Person (Patient):	ID Number:	
DOB:	Age:	
Physician Information		
PCP:	Phone:	Fax:
Requesting MD:	Phone:	Fax:
Office Contact:	Phone:	Fax:
Vendor Information		
Vendor Name:	Address:	
TIN:	Contact Name:	
Phone:	Fax:	
Clinical Information		
Diagnosis:		
Height:	Current Weight:	Percentile:
Current diet:		
Previous formula(s) or food(s) trialed (included dates and reason for discontinuing):		
Percent of nutrition from formula:		
Exact formula and dose as it appears on the prescription:		
Billing Information		
ICD-10 Code(s):	HCPCS Code(s):	Units Requested (per month):

The following are **Required** before request will be processed:
☐ Current clinical notes
☐ Documented clinical notes of retrial of milk and/or soy
☐ Growth chart(s) or BMI history
☐ Pediatric Gastroenterologist or allergist consultation
☐ Current nutritionist's report, including nutritional and caloric intake, and caloric goals