



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):	HCPSC Code(s):	Units Requested (per month):

The following are Required before request will be processed:
<input type="checkbox"/> Current clinical notes
<input type="checkbox"/> Documented clinical notes of retriial of milk and/or soy
<input type="checkbox"/> Growth chart(s) or BMI history
<input type="checkbox"/> Pediatric Gastroenterologist or allergist consultation
<input type="checkbox"/> Current nutritionist's report, including nutritional and caloric intake, and caloric goals

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