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## 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 5<sup>th</sup> 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.

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Signature \_\_\_\_\_ Date \_\_\_\_\_ Print name \_\_\_\_\_

Local WIC Agency phone number \_\_\_\_\_

Contact person \_\_\_\_\_

(This form was developed by the State WIC office, Texas Dept. of Health)