
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)