

WIC EBT Formula Drop Ship Order Form

To be completed by WIC Clinic:

LA/Clinic#: _____ Clinic Phone: _____ Date of Order: _____

Clinic Contact: _____ Benefit Month: _____

Participant Name: _____ PAN#: _____

Vendor Store Name: _____ Vendor Name: _____

Vendor Rep. Contacted: _____

Formula Requirements:

Name	Size & Form	Code	Quantity	Unit Price

SHIP TO CLINIC/ Other Address*:

Special Shipping Instructions:

*State Agency approval REQUIRED for shipments to non-LA/Clinic address

To be completed by Vendor: _____ WIC Account #: _____ Outlet#: _____

UPC #	Pkg. (can or case)	Pkg. Price	Qty. Shipped	Claim Price
Date Shipped:				
Vendor Signature:	Vendor Ref #		Total Formula Cost: Shipping & Handling: Total Cost:	

To be completed by LA/Clinic Staff receiving and storing ordered formula(s):

Date shipment received: _____ Initials: _____

 Signature of Client/ Parent / Guardian receiving formula

 Date

LA/Clinic: Fax signed form to =vendor when all shipments have been issued/signed for by the parent/guardian

Vendor mail to: WIC PROGRAM – FIRS UNIT 4616 W. Howard Lane – Suite #275 Austin, Texas 78728	Claim File Name:	Promo/ Claim Number:
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