



MEDICAL FOOD ORDER FORM

Phone: 877-379-9860
eFax: 360-326-1502
Email: sales@zoiapharma.com

Referral Date: _____
Clinic Dietitian/Contact: _____
Phone: _____ Email: _____

To ensure timely processing, please complete and submit with insurance cards (front & back), LMN signed by prescriber, and recent clinical notes

| Patient Detail | | | |
|---|----------------|---|--|
| Name: | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | DOB: |
| Parent or Legal Guardian, where applicable: | | | |
| Address: | City: | State: | Zip Code: |
| Phone: | Email Address: | | |
| Allergies: | Height: | <input type="checkbox"/> inches <input type="checkbox"/> cm | Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Emergency Contact Name: | Relationship: | Phone: | |

| Insurance Detail | | |
|---|------------------|--------|
| <input type="checkbox"/> Information attached (including front and back of insurance cards) | | |
| Primary Plan Name: | Subscriber Name: | DOB: |
| ID #: | Group #: | Phone: |
| Secondary Plan Name: | Subscriber Name: | DOB: |
| ID #: | Group #: | Phone: |

| Prescriber Detail | | |
|--|------|------------|
| Prescriber Name: | NPI: | License #: |
| Preferred Communication Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email | | |
| Address: | | |
| Phone: | Fax: | Email: |

| Order | | |
|---|---------------|-------------|
| ICD-10 / Diagnosis Description (select): <input type="checkbox"/> E70.0: Classical phenylketonuria <input type="checkbox"/> E70.1 Other hyperphenylalaninemias <input type="checkbox"/> Other: | | |
| Medical Food | Units Per Day | Boxes/Month |
| | | |
| | | |
| | | |

Supply as directed x 1 year

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Pentec Health may contact this patient for purposes of completing the referral process.

Prescriber Signature: _____ Date: _____

Confidential Health Information: This document may contain Protected Health Information (PHI), as defined by the federal HIPAA Privacy Rule (45 C.F.R. Part 160 and Part 164, Subpart E). It is being faxed to you after receiving appropriate Individual authorization or under circumstances that do not require Individual authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate Individual authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and/or state laws and regulations.

Important warning: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.