



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: _____

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