



COVERAGE ASSISTANCE FORM

All questions contained in this form are strictly confidential and will become part of your medical record.

PATIENT INFORMATION

Last Name:	Middle Initial:	First Name:
Date of birth:	SSN (optional):	Phone:
Address:		
City:	State:	ZIP Code:
Email:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employment Status: <input type="checkbox"/> Child <input type="checkbox"/> Employed F/T <input type="checkbox"/> Employed P/T <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Other		

Responsible Party/Parent/Caregiver (Guarantor) Information

Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:		
Last Name:	First Name:	Phone:

GENETIC DISORDER

Disorder:	Current Medical Food:
Amount Per Day:	Current Supplier (i.e. DME/Pharmacy):

CLINIC INFORMATION

Clinic:	Physician/Dietitian:	
Phone:	Fax:	Email:

PRIMARY INSURANCE INFORMATION

Insurance Name:	Phone:	
Member ID No.:	Group No.:	
Primary Holder Name:	Date of Birth:	Relationship to Policy Holder:

SECONDARY INSURANCE INFORMATION (IF ANY)

Insurance Name:	Phone:
Member ID No.:	Group No.:

Other Information:

Authorization for Release of Health Information: I authorize this information contained herein to be shared with the National PKU Alliance and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical food reimbursement support. Such information is furnished in compliance with **HIPAA** to allow for the best service. Nonetheless, if you do not wish for this information to be shared with the National PKU Alliance call Christine Brown at (715) 437-0478 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.

Signature of claimant:	Date:
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Please fax or email completed form to: Compassion Works Medical, LLC Partners with NPKUA (National PKU Alliance), Attn: Raenette Franco, CBCS – Medical Food Reimbursement Specialist/Consultant, Fax (973) 387-1223 or Email raenettef@compassionworksmrs.com.

****Please attach a prescription and Letter of Medical Necessity to complete coverage assistance support****