UnitedHealthcare
COMMUNITY & STATE

Metabolic Nutrition Product Order Request

For Medicaid/Health Choice Patients Client Information

Client Name _____**DOB** _____
Medicaid #_____ **Health Choice #** _____
Parent/Guardian Name_____ **Phone (home)**_____
Address_____ **Phone (other)**_____
City_____ **State**_____ **Zip**_____ **County**_____
Diagnosis (Inborn Error of Metabolism) _____
For Children < 5 Years of Age and Women Who Are Pregnant or Postpartum (within 1 year): FAX REQUEST TO: NCDHHS NUTRITION SERVICES BRANCH @ (919) 870-4820

Nutrition Product Information

Product Name / Product #	Manufacturer	# cases ordered (per prescription)
1 -		
2 -		
3 -		

Requesting Agency Information

Clinician Contact (print) _____ **Agency** _____
Phone_____ **Fax**_____ **email:** _____

Order Information

For IHC Use Only

Medicaid ☐No ☐Yes Health Choice ☐No ☐Yes
Letter to LA ☐Standard pick-up ☐WIC Certification/Recertification with pick-up
Date Ordered_____ Est Del Date_____ Rep. Name_____
Account # _____ PO#_____ Reference #_____
Issues w/order: ☐Back ordered ☐Reduced order ☐Split/partial order (2+shipments) ☐Other : _____
Date Ordered_____ Est Del Date_____ Rep. Name_____
Account # _____ PO#_____ Reference #_____
Issues w/order: ☐Back ordered ☐Reduced order ☐Split/partial order (2+shipments) ☐Other : _____

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1 - _____
2 - _____ Date order confirmation faxed to WIC _____
3 - _____ Date order confirmation faxed to requesting agency_____