

Women, Infants and Children (WIC) Medical Formula and Foods Documentation

Please complete sections A and D for all patients.
 For medical formula/foods, complete section B.
 For soy beverage, complete section C.
 Please fax form to WIC clinic or have WIC participant return form to clinic.

WIC clinic:
WIC fax #:
Attention:

A. Patient information	
Patient's name (Last, First, MI):	DOB:
Parent/Caregiver's name (Last, First, MI):	
Medical diagnosis/qualifying condition: (Justifies the medical need for formula/food — Include ICD-9 code if available)	
Medical documentation valid for: <input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mo. <input type="checkbox"/> 3 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 5 mo. <input type="checkbox"/> 6 mo. (reauthorization required every six months)	

B. Medical formula/medical food and WIC supplemental foods			
Name of medical formula/medical food requested:			
Prescribed amount: <input type="checkbox"/> maximum allowable OR <input type="checkbox"/> _____ <i>per day</i>			
Special instructions/comments:			
Supplemental foods: In addition to the medical formula/food, supplemental foods appropriate to the WIC participant category will be provided. Please mark the appropriate boxes below to indicate any foods that would be contraindicated and/or require special instructions specific to the patient's medical diagnosis.			
<input type="checkbox"/> No supplemental foods: Offering food is contraindicated at this time; omit all supplemental foods and provide medical formula only.			
WIC Participant Category	WIC Supplemental Foods To Omit		Restrictions/Special Instructions
Infants (6-12 months)	<input type="checkbox"/> Infant cereal	<input type="checkbox"/> Infant fruits/vegetables	
Children (13-60 months) and Women	<input type="checkbox"/> Milk*	<input type="checkbox"/> Cheese	
	<input type="checkbox"/> Eggs	<input type="checkbox"/> Peanut butter	
* WIC provides low fat milk for children >2 years and women. Participants receiving medical formula/foods and who need additional calories can qualify to receive whole milk . To authorize this request, please check here <input type="checkbox"/> and initial: _____.			

C. Soy Beverage (for children 13-60 months)	
Mark the qualifying condition that justifies the need for soy beverage as a milk substitute (personal preference is not a qualifying condition).	
<input type="checkbox"/> Milk allergy	<input type="checkbox"/> Severe lactose intolerance
<input type="checkbox"/> Vegan diet	<input type="checkbox"/> Other: _____

D. Health care provider information		
Signature of health care provider:		
Provider's name (please print):		<input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> DO <input type="checkbox"/> NP
Medical office/clinic:		
Phone #:	Fax #:	Date:

WIC USE ONLY	Approved by:	Date:	WIC ID:
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