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: ☐ M ☐ F	DOB:	
Parent or Legal Guardian, where applicable:				
Address:	City:		State:	Zip Code:
Phone:	Email Address:			
Allergies:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg
Emergency Contact Name:	Relationship:		Phone:	

Insurance Detail

☐ 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: ☐ Phone ☐ Fax ☐ Email

Address:

Phone: Fax: Email:

Order

ICD-10 / Diagnosis Description (select):

☐ E70.0: Classical phenylketonuria ☐ E70.1 Other hyperphenylalaninemias ☐ 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:**