NEWBORN SCREENING BENEFITS PRESCRIPTION REQUEST FORM

TEXAS Health and Human Services

Texas Department of State Health Services

☐ **IMMEDIATE MEDICAL NEED** ☐ **NEW**

☐ **RENEWAL** ☐ **ADD** ☐ **CHANGE PRESCRIPTION**

Client Account #:_____ Expiration Date:_____

Client's Name:_____

Client's Diagnosis:_____

Applicant Pregnant? ☐ **YES** ☐ **NO** Expected Due Date: _____

DOB:_____ Gender: ☐ Male ☐ Female **Spanish Speaking Only** ☐ **YES** ☐ **NO**

Parent/Guardian:_____ Phone #:_____

Address:_____ City:_____ Zip:_____

Shipping address if different from above:_____

VENDOR CHANGE: ☐ *Pharmacy or* ☐ Medical Foods Distributors ** ***Explain change below***

Current Vendor:_____*(check new vendor below)*

Explanation: _____

Low Protein Foods: (include last month order placed) _____

Medical Foods (Formula or Low protein foods) Distributors:	**Pharmacy Provider:**	**Services:**
☐ PKU Perspectives ☐ Cambrooke Therapeutics Inc.	☐ Aapex ☐ Compounding Shop ☐ Davila ☐	☐ Office Visits ☐ Laboratory

Low Protein Foods: ☐ Yes ☐ No ($300 Limit)

List each of the prescribed items in the appropriate category below: **

Medications:_____

Vitamins ($300 Limit):_____

Dietary Supplements ($1,500 Limit):_____

Medical Food (Formula):_____

**** Change in prescription or a new item please include medical necessity:** _____

_____

Physician Specialist/Facility:_____

Dietitian/RN:_____ Phone:_____

Email Address:_____ Fax:_____

Dietitian/RN Signature:_____ Date:_____

NBS BENEFITS ONLY: **Approved**: ☐ **YES** ☐ **NO** Effective Dates: _____

NBS Benefits Staff:_____ Date: _____

NBS Medical Director signature is required if requested benefits or services are not listed in allowable NBS Benefits List.

Approved: ☐ **YES** ☐ **NO** ☐ **This Disorder Only** ☐ **All Disorders** ☐ **This Client Only**

Reason for Denial: _____

NBS Medical Director:_____ Date: _____

Send completed form to NBS Benefits Fax: 512-776-7593 or E-mail: NBSbenefits@dshs.texas.gov
Questions? Call 512-776-2983 or 800-252-8023 ext. 2983