



NEWBORN SCREENING BENEFITS PRESCRIPTION REQUEST FORM

Texas Department of State
Health Services

Date: _____

☐ IMMEDIATE MEDICAL NEED	☐ NEW
☐ RENEWAL	☐ ADD ☐ CHANGE PRESCRIPTION

Client Account #: _____ Benefits 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 #: _____

Home 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) Reason for change: _____ Date of last order placed with current vendor: _____		
Medical Foods Distributors: Low Protein Foods (\$300 limit) Yes No ☐ PKU Perspectives ☐ Cambrooke Therapeutics Inc.	Pharmacy Provider: Aapex Compounding Shop Pentec Health	Services: Office Visits Laboratory

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

Medications: _____

Vitamins (\$300 Limit): _____

Dietary Supplements (\$1,800 Limit): _____

Medical Food (Formula) _____

Labs:	Doctors Visits	Diagnostic	Other	# of visits
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** For Change in prescription or new item please list medical necessity

Physician Specialist and Facility: _____

Dietitian/RN: _____ Phone: _____

Email Address: _____ Fax: _____

Dietitian/RN Signature: _____ Date: _____

NBS BENEFITS ONLY: Approved: YES NO Effective Dates: _____	
NBS Benefits Staff: _____ Date: _____	
The following items/ services are not listed as allowable NBS Benefits list _____	
NBS Medical Director signature is required if requested benefits or services are not listed in the 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