solace
NUTRITION

10 Alice Court • Pawcatuck, CT 06379 • toll free (888) 8-SOLACE • www.solacenutrition.com

INSURANCE COVERAGE ASSISTANCE FORM

All fields must be completed

1. FIRST NAME / MIDDLE INITIAL / LAST NAME	2. DATE OF BIRTH
3. STREET ADDRESS / CITY / STATE / ZIP CODE	4. HOME/PREFERRED PHONE NUMBER
5. EMPLOYMENT STATUS: ☐ CHILD ☐ EMPLOYED F/T ☐ EMPLOYED P/T ☐ UNEMPLOYED ☐ DISABLED ☐ SELF-EMPLOYED ☐STUDENT ☐OTHER	6. EMAIL

Diagnosis

7. DIAGNOSIS	**8.** CURRENT MEDICAL FOOD	**9.** DAILY DOSE	**10.** CURRENT SUPPLIER

Clinical Information

11. DIETITIAN/PHYSICIAN	**12.** CLINIC	**13.** PHONE	**14.** FAX

Responsible Party/Parent/Caregiver (Guarantor) Information

15. RELATIONSHIP TO PATIENT: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ PARENT ☐ OTHER ________________

16. FIRST NAME / MIDDLE INITIAL / LAST NAME	**17.** PHONE NUMBER

Primary Insurance Information

18. INSURANCE NAME	**19.** PHONE NUMBER	**20.** MEMBER ID#	**21.** GROUP NUMBER
22. MEMBERS NAME	**23.** MEMBERS DATE OF BIRTH	**24.** RELATIONSHIP TO PATIENT	

Secondary Insurance Information

25. INSURANCE NAME	**26.** PHONE NUMBER	**27.** MEMBER ID#	**28.** GROUP NUMBER

Authorization for Release of Health Information: *I hereby authorize Solace Nutrition to release healthcare information. This information contained herein may be shared to Solace Nutrition and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical food reimbursement support. Such information is furnished in compliance with* ***HIPAA*** *to allow for the best service. Nonetheless, if you do not wish for this information to be shared with Solace Nutrition call (401) 352-4963 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.*

Signature: ____ **Relationship to patient:** __________________________________ **Date:** _________________________
(self, caregiver, parent, clinician)

Please fax or email completed form to: Attn: Insurance Support • Fax (401) 633-6066 or Email info@solacenutrition.com.
Please attach a prescription and Letter of Medical Necessity with this form ***

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