

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	
5. EMPLOYMENT STATUS:		<input type="checkbox"/> CHILD	<input type="checkbox"/> EMPLOYED F/T	<input type="checkbox"/> EMPLOYED P/T		6. EMAIL
<input type="checkbox"/> UNEMPLOYED		<input type="checkbox"/> DISABLED	<input type="checkbox"/> SELF-EMPLOYED	<input type="checkbox"/> STUDENT	<input type="checkbox"/> OTHER	
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: <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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 ***

Products designed by healthcare professionals

Insurance Coverage Checklist

The Solace Insurance Coverage Assistance Form completed.

A letter of medical necessity filled out by your primary care provider.

Any clinical paperwork that your doctor's office can provide.

The RX with the Solace product name clearly written.

Photos of the front and back insurance cards associated with the patient.

