FOR MEDICAL PROFESSIONALS

Statement of Medical Necessity for GERBER® EXTENSIVE HA® FORMULA

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Patient/Guardian Name _____ Relationship to Patient _____

Street Address _____ City/State/Zip _____

Home Phone #_____ Work/Cell # _____ Social Security # _____

Allergies _____ Patient/Caregiver Primary Language _____

Gender: ❒ Male ❒ Female

INSURANCE INFORMATION

❒ ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD

Primary Insurance Company _____ Secondary Insurance Company _____

Primary Insurance Company Phone # _____ Secondary Insurance Company Phone # _____

Subscriber Name _____ Subscriber Name _____

Subscriber ID _____ Subscriber ID _____

Policy/Employer/Group # _____ Policy/Employer/Group # _____

DIAGNOSIS

Gerber® Extensive HA® formula is the only brand of hypoallergenic formula made with 100% whey protein extensively hydrolyzed, probiotic *Bifidobacterium lactis* (*B. lactis*) to help promote a balanced microbiota, and 49% MCT oil to facilitate fat absorption. Gerber® Extensive HA® formula is a term infant formula that may be an infant's sole source of nutrition for up to 6 months of age and a major source of nutrition for 0 to 12 months of age.

Diagnosis	**ICD 10 Code**
❒ Allergy to milk products (cow's milk)	Z91011

Related symptoms caused by cow's milk protein allergy	**ICD 10 Code**
❒ Infantile (acute) (chronic) eczema	L2083
❒ Allergic and dietetic gastroenteritis and colitis	K522

Approval for this request for insurance coverage and reimbursement of Gerber® Extensive HA® formula will make a significant impact on the health of my patient.

Continued...

Statement of Medical Necessity for
GERBER® EXTENSIVE HA® FORMULA

Continued...

MEDICAL ASSESSMENT

Description of my patient's health and nutritional status:

_____

_____

_____

RECOMMENDED PRODUCT

❒ **Gerber® Extensive HA® formula**

HCPCS CODE	B4161
Reimbursement Code	50000-0598-52
Unit Size	14.1 oz (400 g)
Yield/Unit	96 fl oz
Case UPC	000 5000048519 2

DOSAGE INFORMATION

Based on my patient's current diagnosis and nutrient needs for growth, I am prescribing _____calories and _____ ❒ oz ❒ mL per day

PRESCRIBER INFORMATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I also acknowledge that I have obtained the legal guardian's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe **Gerber® Extensive HA® formula** was based solely on my determination of medical necessity set forth herein.

Prescriber Name _____ Physician Provider/NPI # _____

Phone # _____ Physician Provider/Tax ID # _____

Name of Contact Person_____ Contact Phone # _____ Fax #_____

Street Address _____ City/State/Zip _____

Prescriber Signature _____ Date _____

* The list of diagnoses contained in this Statement of Medical Necessity (SMN) is not all-inclusive. It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Gerber Products Company does not guarantee that the use of any information provided in this SMN will result in coverage or payment by any third-party payer.

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