The Neocate Assistance Program (NAP)

Instructions

The mission of Nutricia North America (NA) is to improve lives through specialized nutrition. Toward that end, Nutricia-NA administers the Neocate Assistance Program (NAP). The NAP is designed to assist economically/financially disadvantaged infants obtain Neocate infant formula. While its stated purpose is philanthropic, the NAP program is not designed to replace other available financial resources nor remove all financial responsibility from recipients, in every instance. As a result, the Neocate Assistance Program should be considered the payer of last resort. Applicants must be legal residents of the U.S. and not have third party coverage for nutritional therapy.

Only fully completed applications will be considered for assistance review. Failure to complete any section or to provide all required documentation will delay the review process. Incomplete applications will be returned.

Part 1. Information From Physician

Can be completed by the physician, office staff, or other healthcare professional coordinating care but must be signed by the Physician. Please carefully review the certification and then sign and date the application.

Note to health care providers responsible for completing the application:

All information necessary for the completion of the application is to be provided in accordance with all applicable Federal and state laws, including, but not limited to the Health Insurance Portability and Accountability Act of 1996.

Part II. Information from Applicant: Must be completed by applicant or applicant's representative.

1. Monthly household income is required. Income includes salary, pension, Social Security income, etc. for all members in the household.
2. Documentation of income is required. Documentation includes a Federal tax return*, W2, pay stub, Social Security Benefit Letter, etc. for all members of the household.**
3. A copy of the letter of WIC, Medicaid, and/or Social Security denial or a copy Medicare QMB/SLMB statement and Medicare card is required if applicable.
4. If hardship is the result of applicant's existing health benefits refusal to cover nutritional therapy, a copy of the initial denial letter and the denial of the medical necessity appeal is required.
5. Please carefully review the applicant certification and then sign and date the application. Provide documentation of authorization if individual signing for applicant is someone other than a relative of the applicant.

When all sections of the application have been completed, fax or mail the completed application and associated documentation to Nutricia for eligibility for review.

Approval and Shipment

The Physician's Office and applicant will be notified of applicant eligibility. Upon approval into the Neocate Assistance Program, Nutricia North America will begin the product fulfillment process by direct shipment to the applicant's home.

Recertification

Nutricia North America reserves the right to review and/or revise the award at any time.

Questions & Comments

Please contact us:
Phone: 1-800-365-7354, option 8, ext. 1200
Fax: 1-877-777-0164
Hours: Mon-Fri 10:00 am - 6 pm, ET

NUTRICIA Neocate®

Applications are available by calling **1-800-365-7354, option 8, ext. 1200** or visiting **www.Neocate.com**

NUTRICIA Advanced Medical Nutrition

* Required

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FOR NUTRICIA USE ONLY
Request #:

Neocate Assistance Program (NAP)
12862 Garden Grove Boulevard, Suite 240 • Garden Grove, CA 92843 • 800-365-7354, option 8, ext. 1200

Part 1: INFORMATION FROM PHYSICIAN

A. PHYSICIAN INFORMATION ❑ Check this box if your address has changed

State License #: DEA #:

Last Name: First Name:

Professional Designation: Primary Specialty: Gender: ❑ M ❑ F

Office Shipping Address (No PO Box):

City: State: Zip:

Office Mailing Address:

City: State: Zip:

Office Contact:

Phone: Fax:

B. NUTRITIONAL THERAPY INFORMATION

Product Name: Flavor:

Amount Needed Per Day: ❑ Calories ❑ Cans ❑ Grams (check one)

_____% of Daily Caloric Intake Needs Administration: ❑ Oral ❑ Tube

Please provide a primary diagnosis that requires the need for nutritional therapy.

Primary Diagnosis:

C. CERTIFICATIONS

1. **Authorization for Release of Health Information:** By signing the Application, I represent to Nutricia North America that I have obtained all the necessary Federal and state consents from my patient to allow me to release health information to the Neocate Assistance Program.
2. **Primary/Care Coordinator Verification:** I verify that the information in this application is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Neocate Assistance Program, I understand that Nutricia will send the nutritional product to the patient's home. Nutricia reserves the right to request additional information if necessary and to change or discontinue this program at any time, without notice. By signing this form, I certify that the applicant is under my ongoing supervision for their nutritional therapy and that I am recommending the aforementioned nutritional product for the applicant. I understand that it is my responsibility to report any adverse events or conditions that may result from the use of the aforementioned nutritional product to Nutricia North America. I acknowledge that I shall not seek reimbursement for any nutritional product provided hereunder from any government program or third-party insurer. I also understand that the applicant's acceptance into the Neocate Assistance Program is not made in exchange for any explicit recommended, or arranged for or provided formulary or other preferential or qualifying status.

Note: Physician may not delegate signature authority. (STAMPS NOT ACCEPTED)

Physician's Signature: Date:

PART II. APPLICANT INFORMATION

Note: Part II of the Application must be attested to by the applicant or applicant's representative. Patients in health care institutions are not eligible. **Applicant must have valid Social Security number to participate.**

A. CONTACT INFORMATION ❑ Please check box to indicate change of address

Social Security #:* Date of Birth: Gender: ❑ M ❑ FF

Last Name: First Name: Middle Initial:

Guardian Name:

Address (No PO Box):

City: State: Zip:

Phone:

* Required

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B. FINANCIAL INFORMATION – DO NOT SEND ORIGINALS

Attach the most current copies of income documents for you and all members of the household. *See instruction section for list of required documents – Part II, section 2.***

_____ Number of people in household including yourself. _____ Number of children in household under age 18.

Monthly income for all in household: $	Social Security: $	Interest / Dividends: $
Disability: $	Pension: $	Child Support/Alimony: $
Salary/Wages: $	Unemployment: $	**Total All Sources: $**

C. HEALTH BENEFIT INFORMATION

Does applicant have Medicare? ❑ Yes ❑ No
If yes, is it: ❑ Part A ❑ Part B
Does the Part B benefit provide coverage for the requested product(s)? ❑ Yes ❑ No
Attach a copy of applicant's Medicare card

Has applicant applied for financial assistance (Medicaid, SSI, etc)? ❑ Yes ❑ No
If yes, has the applicant been denied assistance? ❑ Yes ❑ No ❑ Pending ❑ QMB ❑ SLMB
If yes, provide copy of denial within 2 years.
Does applicant have Medicaid coverage for nutritional therapy? ❑ Yes ❑ No
If no, provide a copy of denial letter OR published policy stating the Neocate Product requested is not covered.
Is the applicant eligible for food stamps? ❑ Yes ❑ No

Does applicant have benefits through other state/government program (i.e., WIC, ADAP)?
❑ Yes ❑ No ❑ Not applied ❑ Application Pending ❑ Waitlisted ❑ Accepted ❑ Denied
If yes, does the benefit provide (partial or full) coverage for the requested products(s)? ❑ Yes ❑ No
Plan Name: Amount Provided:

Does applicant have benefits through private insurance/HMO? ❑ Yes ❑ No
If yes, does it provide (partial or full) coverage for the requested product(s)? ❑ Yes ❑ No
Plan Name: Amount Provided:
If no, provide a copy of denial letter stating Neocate is not covered.

D. REPRESENTATIVE FOR PURPOSE OF PROGRAM

I permit the Neocate Assistance Program staff to speak with the following person(s) about my application and/or care and sign any documents related to the program on my behalf.

Name: Relationship:

Name: Relationship:

E. CERTIFICATION

In the event that I am eligible for the Neocate Assistance Program (NAP), I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the NAP may send me additional information about the Program, or information about alternate or additional financial assistance. I certify that the information I have provided in this Application is correct and complete.

Applicant's Signature: Date:

Note Applicant's Representative: If the Applicant is unable to sign, or has designated signature authority, a Representative of the Applicant may sign for purposes of this application. However, only certain individuals may qualify as the Applicant's Representative for purposes of this Application. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and and health care status to verify that all responses provided are accurate. An appropriate consent from the Applicant, attesting to the Representative's possession of this knowledge or information must be on file if the Applicant's Representative is someone other than a relative of the Applicant. A person or entity in the supply chain of the product to be received through the Program, including a healthcare provider or pharmacy receiving the free products, may not be named a Representative.

Signature of Applicant's Representative: Date: Relationship:

Note: If the Applicant's Representative is affiliated with a consumer assistance or charitable organization, please list the name of the entity and purpose of the entity under Relationship.