Kentucky Metabolic Food and Formula Provision Financial and Release of Information Form

Authorizations, Agreements and Financial Disclosures

Patient Identification

Patient Last Name: _____

Patient First Name: _____

Patient Date of Birth: _____

Patient's Social Security Number: _____

Patient on Diet? Yes ___ No ____ If no, inactive date _____ University Center _____

Street Address: _____

City _____ State _____ Zip _____

Phone Number _____**Back up phone number**_____

Mother's Name_____ Social Security Number _____

Father's Name _____ Social Security Number_____

Name of Responsible Party _____

Responsible Party **Email Address** _____

To obtain physician prescribed medical formula and medically modified foods, the Maternal and Child Health Division, Department for Public Health (DPH) will assist patients in meeting the costs not covered by their health insurance carrier or other third-party payor. This assistance is to provide to patients with phenylkeonuria (PKU) and similar disorders as designated in 902 KAR 4:035. To do so, the DPH will need to verify your health insurance or other payor source. In participating, you must agree to the following:

A. **Release of Medical Information**: I authorize the release of medical records that may be required to document the medical condition and required treatment. This may include copies of prescriptions.
B. **Release of Health Insurance Information:** I authorize the release from my health insurance carrier or other third-party payor the financial information needed to determine: 1) general coverage status 2) coverage for medical formulas and medically modified foods and 3) limits of coverage imposed. **It is REQUIRED to notify the program at any time of a change of information or insurance status or carrier.**

Health Insurance: Yes ___No___ **If insurance please include copy of front and back or card.**

If Yes, Name of Insurance Company _____

Member ID #: _____ Policy Number: _____ Group Number: _____

Address of Insurance Company _____

Phone Number _____Effective Date _____

C. **Consent to disclose the following financial information:** I agree to disclose the following financial information. This information may be used to explore eligibility for receiving food and formula through Medicaid, KCHIP, or WIC.

Number in Household_____

Medicaid - Yes_____ No ____ KCHIP - Yes _____ No _____
Medicare - Yes_____ No ____ WIC - Yes _____ No _____

Adjusted Gross Income_____
(From Line 34 Federal Tax Form 1040, line 21 Form 1040A, Line 4 1040EZ or Kentucky State Tax Form 740 Line 9 A & 9 B or 740 EZ Line 1)

_____ _____ _____

Signature of Patient, Parents or Guardian Witness Date

D. Consent to coordinate: I agree to provide medical formula and food usage information to the DPH.
E. Quality Assurance: I authorize the DPH or its designated representative to contact me regarding satisfaction or related quality issues.

The signed authorization complies with KRS 194.250 governing the release of privileged information. It assures the confidentiality of information and permits the DPH to contact those agencies having a legitimate interest in the continuity of care. This consent is valid for one year from signature date and required renewal annually for continued participation in this payment program. This consent may be withdrawn at any time.

_____ _____ _____

Signature of Patient, Parents or Guardian Witness Date

If the person to receive the physician prescribed formula and medically modified foods is a minor (under 18 years of age) or has a legal guardian or conservator appointed, then the release needs the signature of the parent, guardian, or conservator.

This record is on file in the office of:

Metabolic Foods & Formula Program
275 East Main St. HS2W-C
Frankfort, KY 40621
Phone: 502-564-2154
Fax: 502-564-1510