WCD WIC Program

Request for Non-Contract Formula or Medical Food

All sections must be complete for consideration to approve non-contract formula or medical food for a woman, infant or child.

WCD WIC Program is required to contract with a formula company to provide formula. Non-contract formulas are not authorized for non-specific formula or food intolerance(s), constipation, spit up, colic or colic symptoms or solely for the purpose of enhancing nutrient intake or managing body weight.

_____ _____ _____/_____

Participant Name | Date of Birth | If premature: weeks gestation & birth weight

_____

Medical condition(s) – must be included to justify request

_____

ICD code(s) – must be included to justify request

_____ _____ _____

Weight | Length/height | Date taken (within 30 days of request)

_____ Amount: [ ] _____ per day **OR** [ ] Maximum allowed

Formula Requested | Requested Duration: [ ] 1 month **OR** [ ] 2 months

_____

Previous Formula(s) used, duration and results

If non-contract formula is approved, retrial of a standard WIC contract formula must occur with results documented before a subsequent non-contract formula request is considered.

Additional Supplemental Foods to include:

If this section left blank, all supplemental foods will be provided at the maximum allowable amount.

[ ] None; supplemental food is contraindicated at this time. Omit all supplemental foods and provide formula/medical food only.

[ ] Healthcare Provider will select appropriate foods below at the maximum allowable amount unless otherwise indicated.

Infants (6-11 months)	[ ]Infant Cereal	[ ]Infant Fruits & Vegetables		[ ]Fresh Fruits & Vegetables (9-11 months)	
Women	[ ]Milk	[ ]Soymilk	[ ]Cheese	[ ]Yogurt	[ ]Eggs
and	[ ]Tofu	[ ]Beans	[ ]Peanut Butter	[ ]Juice	[ ]Whole Grains
Children (1-5 years)	[ ]Infant Cereal	[ ]Breakfast Cereal		[ ]Canned Fish (fully breastfeeding women only)	
	[ ]Infant Fruits & Vegetables			[ ]Fresh or Frozen Fruits & Vegetables	

Healthcare Provider Signature (MD, DO, PA, ARNP, CNS, CNM):_____

Provider's Name (please print): _____ Date: _____

Phone: _____ Fax: _____

Please fax the completed form to the WIC clinic or have your patient return the document to their WIC clinic.

WCD WIC Staff Use Only

_____ Approved_____ Denied_____

WCD WIC Registered Dietitian Signature | Date | For issuance months: _____

WCD WIC Clinic: _____ Phone: _____ Fax: _____

WIC is an equal opportunity provider