Formula4Success®

The Formula4Success® program offers step-by-step, detailed information and support to get the Vitaflo™ products you need. From navigating insurance to finding distributors or suppliers, we can help.

No Cost

Benefit Investigation

Claim Support

Product Access

Enrollment is simple.

1. **Download** the enrollment form for your formula needs.
2. **Work with** your healthcare professional (HCP) to complete the form*. Be sure to sign the patient privacy statement and include a front and back copy of all active health insurance cards.
3. **Email Formula4Success@VitafloUSA.com** or fax the completed form and documents** to 888-485-7193.

*All fields must be filled out to complete the enrollment process.

For HCPs: You can click here to access the Detailed Written Order (DWO) and here for Letters of Medical Necessity (LMN) templates, then send them via email along with recent and/or relevant clinical notes and labs to the **Formula4Success team.

Vitaflo™
Enhancing Lives Together
A Nestlé Health Science Company

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Visit VitafloUSA.com/Formula4Success or call 800-520-6112

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Patient Information (please print)

Patient's legal name _____

Patient's date of birth (mm/dd/yyyy) _____

Name of parent or legal guardian(s) (if patient is under age 18) _____

Shipping address _____

City _____ State _____ Zip _____

Preferred phone number(s) ( ) _____ ( ) _____

Email address _____

Vitaflo product(s) requested _____

Healthcare Provider Information

Clinic _____

Clinic street address _____

City _____ State _____ Zip _____

Please list contact information for Dietician or the HCP that prescribes your formula below.

Name _____

Email _____ Phone number _____ Fax _____

Primary Insurance Information

Insurance provider _____

Policy holder's name _____

Group ID _____

Member ID _____

Insurance provider's phone number ( ) _____

Pharmacy services phone number ( ) _____

Secondary Insurance Information

Insurance provider _____

Policy holder's name _____

Group ID _____

Member ID _____

Insurance provider's phone number ( ) _____

Pharmacy provider's phone number ( ) _____

Patient Consent (required)

Please read and check both of the following:

❑ I have read and agree to the Privacy Statement & Authorization to Share information set forth below.

❑ I give my consent to enroll in the **Formula4Success** program.

Patient's name (print) _____

Patient's representative (print) _____

Patient's signature, or patient's representative signature (required) _____ Date _____

Authority: ❑ Parent/Legal Guardian ❑ Power of Attorney ❑ Limited Power of Attorney ❑ Other (please specify): _____

Patient Authorization to Share Medical Information Required for Patient Enrollment

By signing below and submitting your information, you authorize **Formula4Success** for Vitaflo™ USA, Inc. ("**Vitaflo**"), to contact you and to collect your personal medical and insurance coverage information and share it with our agents and contractors as well as outside organizations (including healthcare providers and health plans), in order to verify insurance coverage and provide you with reimbursement support for **Vitaflo** products. You acknowledge that **Vitaflo** does not guarantee coverage by any insurance plan providers and will not reimburse any claims denied by third party providers. If you want to revoke your consent to access and share your information, you may notify us at any time via email at Formula4Success@VitafloUSA.com

Important Notice:

The information on this site is for informational purposes only and does not constitute legal advice. All medical necessity determinations must be made by the responsible clinician. Information on this site is obtained from third-party sources and is subject to change without notice due to frequently changing laws, regulations and guidance. Users should contact the appropriate payers for specific questions regarding coding, coverage, or reimbursement. **Vitaflo** does not guarantee coverage by any insurance plan and will not reimburse any claims denied by third-party payers.

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