NEBRASKA **E**LEMENTAL

FORMULA **R**EIMBURSEMENT

PROGRAM

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Application Form

Name of Applicant (person who uses the formula):_____

Birth Date of Applicant: _____

Applicant's Social Security Number: _____

Name of Parent/Guardian if Applicant is a Minor: _____

Parent/Guardian's Social Security Number if Application is a Minor: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

This form has multiple pages. Be sure to complete each page.

- Read the following conditions and sign and date, showing you understand and agree with these conditions:
  - I have read the all program information or it has been read to me, at http://dhhs.ne.gov/Pages/Elemental-Formula-Reimbursement-Program.aspx
  - Reimbursement is for out-of-pocket costs, not covered by private insurance, Medicaid, Medicare, other government insurance program, WIC or charitable grants.
  - 50% of this out-of-pocket cost will be reimbursed up to a total not to exceed $12,000 in a 12-month period (July 1st to June 30th). Reimbursements will be made on a first-come, first-served basis.
  - Receipts dated on or after the Physician's Statement signature date are eligible for reimbursement. Any receipt prior to this date will not be reimbursed. Receipts more than 6 months old from the approved application date will not be reimbursed regardless of Physician's Statement.

Nebraska Elemental Formula Reimbursement Program—Lifespan Health Services Unit
DHHS.ElementalFormulaReimbursementProgram@nebraska.gov –Phone # 402-471-0158
http://dhhs.ne.gov/Pages/Elemental-Formula-Reimbursement-Program.aspx

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You must place check in ALL the boxes that are applicable to you—

☐ My minor child or I have no private health insurance.

OR

☐ My minor child or I have private health insurance that has denied coverage of the formula and I have attached a copy of the insurance company's denial.

☐ My minor child or I is not enrolled in WIC.

OR

☐ My minor child or I is enrolled in WIC but, I have purchased additional formula in excess of that provided by WIC.

☐ My minor child or I is/are not enrolled in Medicaid, Medicare, or other government insurance program such as Tricare.

AND

☐ I have not received reimbursement from a charitable grant for this purpose.

- Reimbursements will be made only when all required information is provided and applicant's eligibility is determined.
- All statements in this Application Form are true and complete;

Signature of Applicant or Parent/Guardian if Applicant is a Minor:

_____ Date: _____

REMINDER

The submitted application will be reviewed and approved or denied. You will be notified through email of the determination. If approved, you will need to complete the Reimbursement Claim Form and submit with attached receipts. The receipts **MUST** clearly show date of purchase, product purchased, breakdown of cost, method/proof of payment, and delivered date of product if applicable.

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Physician's Statement

As the physician for _____, _____
(Patient Name) (Date of Birth)

I certify that this patient has medical necessity for amino acid-based elemental formula for the diagnosis and treatment of:

- ☐ Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins
- ☐ Food-Protein-Induced Enterocolitis Syndrome
- ☐ Eosinophilic Disorders
- ☐ Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

As such, I have ordered the following formula:

- ☐ Alfamino Infant
- ☐ Alfamino Jr.
- ☐ Elecare
- ☐ Elecare Junior
- ☐ Neocate Splash 8 oz. Drink Box
- ☐ Essential Care Jr.
- ☐ Equacare Jr.
- ☐ Neocate Infant
- ☐ Neocate, Junior 14.1 oz.
- ☐ PurAmino
- ☐ Tolerex
- ☐ Vivonex Pediatric 1.7 oz. Packet
- ☐ Vivonex Plus
- ☐ Vivonex RTF
- ☐ Vivonex T.E.N. 2.84 oz. Packet

Start date physician acknowledges the formula was necessary: _____

*Receipts for product purchased prior to the start date will not be reimbursed. Receipts for product purchased more than 6 months prior to the application approval date will not be eligible for reimbursement regardless of the start date.

Physician's Signature: _____ Date: _____
Printed Name: _____

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United States Citizenship Attestation

For the purpose of complying with Neb. Rev. Stat. 4-108- through 4-114, I attest as follows:

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my or my minor child's lawful presence in the United States.

☐ I am or my child is a citizen of the United States

OR

☐ I am or my minor child is a qualified alien under the Federal Immigration and Nationality Act, my immigration status, and alien number are as follows: _____ and I will provide a copy of my/his/her USCIS documentation.

PRINT NAME OF APPLICANT,
OR PARENT/GUARDIAN IF
APPLICANT IS A MINOR CHILD _____
(first, middle, last)

SIGNATURE OF APPLICANT,
OR PARENT/GUARDIAN IF
APPLICANT IS A MINOR CHILD _____

DATE _____

FOR OFFICE USE ONLY:

Application Approved: _____ Denied: _____ Withdrew: _____

Application Reviewed by: _____ Date: _____

Comments: _____