TEXAS Health and Human Services

Texas Department of State Health Services

NEWBORN SCREENING BENEFITS PRESCRIPTION REQUEST FORM

Date: _____

☐ **IMMEDIATE MEDICAL NEED** ☐ **NEW**
☐ **RENEWAL** ☐ **ADD** ☐ **CHANGE PRESCRIPTION**

Client Account #: _____ Benefits Expiration Date: _____

Client's Name: _____

Client's Diagnosis: _____

Applicant Pregnant? ☐ **YES** ☐ **NO** Expected Due Date: _____

DOB: _____ Gender: ☐ Male ☐ Female **Spanish-Speaking Only** ☐ **YES** ☐ **NO**

Parent/Guardian: _____ Phone #: _____

Home Address: _____ City: _____ Zip: _____

Shipping address if different from above: _____

VENDOR CHANGE: ☐ *Pharmacy or* ☐ Medical Foods Distributors ** ***Explain change below***

Current Vendor: _____ *(check new vendor below)*

Reason for change: _____

Date of last order placed with current vendor: _____

Medical Foods Distributors:	**Pharmacy Provider:**	**Services:**
Low Protein Foods ($300 limit) ☐ Yes ☐ No	☐ Aapex Community Pharmacy	☐ Office Visits
☐ PKU Perspectives ☐ Sentido Health	☐ Compounding Shop Pharmacy	☐ Laboratory
☐ Ajinomoto Cambrooke ☐ Zoia Pharma	☐ Pentec Health, Inc.	

List each of the items in the appropriate category below: **

Medications: _____

Vitamins ($300 Limit): _____

Dietary Supplements ($1,800 Limit): _____

Medical Food (Formula) _____

Labs: Doctors Visits ☐ Diagnostic Other ☐ # of visits_____

* For Change in prescription or new item please list medical necessity

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Physician Specialist and Facility: _____

Dietitian/RN: _____ Phone: _____

Email Address: _____ Fax: _____

Dietitian/RN Signature: _____ Date: _____

NBS BENEFITS ONLY: **Approved**: ☐ **YES** ☐ **NO** Effective Dates: _____

NBS Benefits Staff: _____ Date: _____

The following items/ services are not listed as allowable NBS Benefits list _____

NBS Medical Director signature is required if requested benefits or services are not listed in the allowable NBS Benefits List.

Approved: ☐ **YES** ☐ **NO** ☐ **This Disorder Only** ☐ **All Disorders** ☐ **This Client Only**

Reason for Denial: _____

NBS Medical Director: _____ Date: _____

Send completed form to NBS Benefits Fax: 512-776-7593 or E-mail: NBSbenefits@dshs.texas.gov
Questions? Call 512-776-2983 or 800-252-8023 ext. 2983