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: Low Protein Foods ($300 limit) Yes No ☐ PKU Perspectives ☐ Cambrooke Therapeutics Inc.	**Pharmacy Provider:** Aapex Compounding Shop Davila	**Services:** Office Visits Laboratory

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

____

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