



NEWBORN SCREENING BENEFITS
IMMEDIATE MEDICAL NEED PRESCRIPTION REQUEST

Application Date: NBS Account#:

Applicant's Name:

DOB: Gender: Spanish Speaking Only: YES NO

Parent/Guardian: Phone #:

Address: City: Zip:

Ship to address if different from above:

Contracted Provider: Office Visit Laboratory Services

Low Protein Food Manufacturer: PKU Perspectives Cambrooke Foods

Pharmacy: Apex Botica Familiar Davila Medco Westlands Walgreens (Infusion Services Only)

Identify each of the prescribed items in the appropriate category below.

Medications:

Vitamins Limit \$300.:

Dietary Supplements Limit \$1,500.:

Low Protein Foods? Yes No If yes, please advise Client of the Limit \$200/month

Contracted Provider/Facility:

Dietician/Nurse: Phone:

Email Address: Fax:

Signature: Date:

NBS BENEFITS ONLY: Approved: YES NO

Effective Dates:

NBS Benefits Staff: Date:

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

Approved: YES NO All Clients This client only

NBS Medical Director: Date:

Send completed form to NBS Benefits FAX - 512-776-7593 OR Email - irma.hernandez@dshs.state.tx.us Questions? Call (512) 776-2983 or 800-252-8023 ext. 2983