



NEWBORN SCREENING BENEFITS PRESCRIPTION FORM – New/Add/Change

NBS Account#: _____ Expiration Date: _____
 NEW CLIENT RENEWAL CLIENT

Client's Name: _____

Client's Diagnosis: _____

DOB: _____ Gender: Male Female Spanish Speaking Only: YES NO

Parent/Guardian: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

Ship to address if different from above: _____

Current Provider (if applicable): _____

Change Provider: Pharmacy or Low Protein Food

New Low Protein Food Provider:

- PKU Perspectives
- Cambrooke Foods

New Pharmacy Provider:

- Aapex Botica Familiar Davila Medco
- Westlands Walgreens (Infusion Services Only)

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

Medications: _____

Vitamins **Limit \$300/month** _____

Dietary Supplements **Limit \$1,500/month** _____

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

If changes in prescription or items are not on the NBS Benefits approved list, please include medical necessity:

Contracted Provider/Facility: _____

Dietitian/RN: _____ Phone: _____

Email Address: _____ Fax: _____

Dietitian/RN Signature: _____ Date: _____

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

NBS Benefits Staff: _____ Date: _____

**NBS Medical Director signature is required
if requested 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