

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in CHILDREN

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C

SIGNATURE

(Physician, Nurse Practitioner or Physician Assistant)

PRINT NAME

(Physician, Nurse Practitioner or Physician Assistant)

Florida Medical License #

SIGNATURE

(Registered Dietitian/Nutritionist)

PRINT NAME

(Registered Dietitian/Nutritionist)

Dietitian/Nutritionist Florida License #

Nutrition Products Available Through the Ryan White Program

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/ Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ Lbs Kgs IBW/UBW: _____ Lbs Kgs

NOTE: 1 Serving = 1 Can (8 fluid ounces)

Boost Liquid is restricted to Children 18 years and under

Boost Liquid- _____ No. of **SERVINGS per DAY**

Number of Refills Authorized _____

(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above.) Please indicate FLAVOR preference: Vanilla Chocolate Strawberry

Resource Just for Kids is restricted to Children 1 - 10 years of age

Resource Just for Kids- _____ No. of **SERVINGS per DAY**

Number of Refills Authorized _____

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.

Patient's 10 digit MEDICAID Number: _____

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.