**Special Formula Review: XX Agency Date: XX**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| √ | Information is provided & correct |  |  |  |  |  |  |  |  |
| N/A | Information is not applicable |  |  |  |  |  |  |  |  |
| M | Information is missing/blank |  |  |  |  |  |  |  |  |
| X | Information is incorrect |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Participant ID and Initials |  |  |  |  |  |  |  |  |  |  |
| **MRF form: HCP Documentation***(Italicized needs to be in StarLINC)* |  |
| Participant’s name |  |  |  |  |  |  |  |  |  |  |
| DOB |  |  |  |  |  |  |  |  |  |  |
| *Medical diagnosis* |  |  |  |  |  |  |  |  |  |  |
| *ICD code* |  |  |  |  |  |  |  |  |  |  |
| *Formula requested* |  |  |  |  |  |  |  |  |  |  |
| *Formula amount requested* |  |  |  |  |  |  |  |  |  |  |
| *Length of issuance* |  |  |  |  |  |  |  |  |  |  |
| Supplemental foods CPA allowed |  |  |  |  |  |  |  |  |  |  |
| *Supplemental foods HCP omitted* |  |  |  |  |  |  |  |  |  |  |
| *Prescribing HCP—MD/DO/NP/PA name* |  |  |  |  |  |  |  |  |  |  |
| HCP—MD/DO/NP/PA Signature |  |  |  |  |  |  |  |  |  |  |
| HCP Contact information |  |  |  |  |  |  |  |  |  |  |
| *Date of request* |  |  |  |  |  |  |  |  |  |  |
| *Release of information signed* |  |  |  |  |  |  |  |  |  |  |
| Verbal order documentation  |  |  |  |  |  |  |  |  |  |  |
| **StarLINC Documentation** |  |
| Risk Criteria updated |  |  |  |  |  |  |  |  |  |  |
| SAS completed:  |  |  |  |  |  |  |  |  |  |  |
| DR name and credentials  |  |  |  |  |  |  |  |  |  |  |
| formula  |  |  |  |  |  |  |  |  |  |  |
| dx/ICD code  |  |  |  |  |  |  |  |  |  |  |
|  amount formula  |  |  |  |  |  |  |  |  |  |  |
| LOI  |  |  |  |  |  |  |  |  |  |  |
| if provided by Medicaid/MCO |  |  |  |  |  |  |  |  |  |  |
| Nutrition assessment summary including FP adjustments and recommendations |  |  |  |  |  |  |  |  |  |  |
| Food package assignment c/w diagnosis and CPA assessment |  |  |  |  |  |  |  |  |  |  |
| Food package assignment c/w HCP directions if applicable |  |  |  |  |  |  |  |  |  |  |
| HCP consultation if applicable |  |  |  |  |  |  |  |  |  |  |
| Medicaid/MCO providing formula  |  |  |  |  |  |  |  |  |  |  |
| Receives formula through another program checked off |  |  |  |  |  |  |  |  |  |  |
| Number of months benefits issued. |  |  |  |  |  |  |  |  |  |  |
| **FUN\_HP appointment w/ CPA**  |  |  |  |  |  |  |  |  |  |  |
| Assessment note  |  |  |  |  |  |  |  |  |  |  |
| FP adjustment |  |  |  |  |  |  |  |  |  |  |
| **FUN\_HP appointment w/ CPA**  |  |  |  |  |  |  |  |  |  |  |
| Assessment note |  |  |  |  |  |  |  |  |  |  |
| FP adjustment |  |  |  |  |  |  |  |  |  |  |
| **FUN\_HP appointment w/ CPA**  |  |  |  |  |  |  |  |  |  |  |
| Assessment note |  |  |  |  |  |  |  |  |  |  |
| FP adjustment |  |  |  |  |  |  |  |  |  |  |

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| **ID# and Initials** | **Notes** |
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