Reimbursement Support Form

Please complete and send this form to Envara Health Reimbursement Support at: reimburse@envarahealth.com or fax to **(484) 930-0761**

Patient Information

Patient Name ______ Street Address ______ Date of Birth ______ Gender ______

Parent/Guardian Name ______ City/State/Zip ______ Cell Phone # ______

Relationship to Patient ______ Email ______ Home/Work # ______

Medical Necessity Support Information

I have attached the following information to help establish medical necessity:

- ☐ Copy of both sides of patient's insurance card
- ☐ Letter of Medical Necessity signed by MD
- ☐ Patient demographic information from EMR
- ☐ Clinical notes including: latest nutritional assessment and growth charts (pediatric only)

HealthWell Cystic Fibrosis (CF) Vitamins and Supplements Fund Information

☐ Interested in accessing HealthWell for Encala

HealthWell ID# ______

Diagnosis

The list of diagnoses contained in this form is not all-inclusive.

Required: Please indicate ICD-10 code(s)

- ☐ Cystic fibrosis: E84.0
- ☐ Exocrine pancreatic insufficiency: K86.81
- ☐ Pancreatic steatorrhea: K90.3
- ☐ Malabsorption: K90.0
- ☐ Malabsorption due to intolerance: K90.49
- ☐ Underweight: R63.6
- ☐ Other, please specify: ______

Preferred DME or Pharmacy Suppliers ______

Product and Dosage Information

Based on my patient's current medical condition, I recommend:

☐ Encala

- ______ doses/day
- One clinical dose is equal to 18.4g

  Recommended Daily Dose
<12 years = 2 (18.4g) servings
≥12 years = 3 (18.4g) servings
- Application (check all that apply)

  ☐ oral ☐ tube feeding
- Length of need ______

Signature ______ Provider NPI #/Tax ID # ______ Name of Primary Clinical Contact ______

Date ______ Provider Medicaid ID # ______ Primary Clinical Contact Phone # ______

Provider Name ______ Facility Name ______ Primary Clinical Contact Fax # ______

Provider Phone # ______ Facility Address ______ Primary Clinical Contact E-mail ______

Provider Email ______ City/State/Zip ______

Preferred Contact Method: ☐ phone ☐ email

Provider Information

☐ I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By signing above, I also acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed to an authorized supplier. I certify that my decision to prescribe Encala was based solely on my determination of medical necessity set forth herein.

☐ By signing above, I hereby attest that I am the prescribing provider and I agree to submit this request to Envara Health Reimbursement Support Program. I have determined that the Encala product I have recommended is medically appropriate and I have explained such to my patient. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996) to Envara Health for the purpose of providing general reimbursement support and assisting in initiating or continuing therapy. My signature above indicates that I understand the information provided above and I certify that the patient has provided my office with written consent and authorization to proceed with this assessment. I understand that if I have not secured consent from my patient to pursue insurance assessment, Envara Health will be unable to proceed with this request.

101 Lindenwood Drive
Suite 125, Malvern, PA 19355
© 2021 Envara Health
ENV-1309 09/2021

Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure accuracy for the services and items provided. Providers should consult with the insurance plan for complete and accurate details concerning documentation for claims. Envara Health does not guarantee reimbursement by any third-party insurance plan and will not reimburse physicians or providers for claims denied by third-party insurance plans.