Encala® 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 #

Insurance Information

Attach a copy of both sides of patient's insurance card **AND** a copy of the patient demographic information from EMR.
This is required to complete the reimbursement support request.

☐ I have attached patient insurance and demographic information, including member identification and insurance plan contact information.

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.

Envara HEALTH
101 Lindenwood Drive
Suite 125, Malvern, PA 19355

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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.