trumacro™ NUTRITION

To: trumacro™ Nutrition customer service team

Fax #: (833) 695-8362

RE: Medical Food Consent Form

FROM:	
FAX #	
PHONE #:	
# PAGES:	
DATE:	

Fax the completed form to the number indicated above.
Please make sure to include:

- All requested information in form
- Provider signature
- Patient/Responsible Party Signature
- Contact information for Patient/Responsible Party

To the health care provider (HCP): You are being asked to complete this form in order to provide documentation that the patient indicated below is under your medical supervision and that you recommend trumacro™ Nutrition ketogenic medical foods as part of your patient's nutritional plan. Please fill out the form in its entirety.

PATIENT'S NAME*	First	Middle	Last
PATIENT'S DOB MM/DD/YYYY			
DIAGNOSIS	Primary	Secondary	
DIETARY BACKGROUND	Ketogenic Diet ☐	Low Glycemic Index ☐	Standard American ☐ Other

HCP NAME*	First	Middle	Last	
HCP POSITION	Medical Doctor ☐	Dietitian ☐	Nurse ☐	HCP PROVIDER NUMBER*
HCP EMAIL*				
CLINIC NAME				
CLINIC ADDRESS	Street			
	City	State	Zip	Country

Medical Food Recommended for this patient (Check one, use separate form if more than one formula is indicated)*

KETOGENIC BHB (UNFLAVORED) (The unflavored BHB formula is recommended for tube-fed patients only.) ☐	KETOGENIC BHB (ORANGE FLAVOR) ☐	KETOGENIC BHB+MCT (LEMON CREME FLAVOR) ☐			
NUMBER OF SERVINGS PER DAY		TAKEN WITH/WITHOUT FOOD		SERVING SIZE/UNIT	
INSTRUCTIONS FOR USE WITH FEEDING TUBE					

HCP SIGNATURE*		DATE*	

I hereby request and authorize Disruptive Nutrition, LLC to release and receive my personal health information (PHI), maintained by my ordering clinician(s), as necessary, to assist in eligibility and benefit verification and to process insurance claims, insurance applications and the fulfillment of product orders. This authorization will expire (5) five years from the date of the signature below. I understand that I can revoke this authorization at any time by writing to Disruptive Nutrition, LLC. However, revocation of this authorization will not affect disclosures made or actions taken before the revocation is received. I also understand that: I am not required to sign this authorization; Federal privacy regulations will no longer apply to the information disclosed and that Disruptive Nutrition, LLC may re-disclose this information; I am entitled to receive a copy of this authorization; a copy of this authorization may be utilized with the same effectiveness as an original.

PATIENT/RESPONSIBLE PARTY SIGNATURE*		DATE*		PATIENT CONTACT #	
NAME OF REPRESENTATIVE*		RELATIONSHIP TO PATIENT			
CONTACT EMAIL* The email in this field must be the email that is used to purchase Medical Foods on trumacro.com.					

Fax completed form to **(833) 695-8362**