Iowa Women, Infants, and Children (WIC) Program

Documentation of Nutrition Products from WIC

The following WIC participant is enrolled in the Medicaid Program. This form documents WIC participation and the amount of formula provided in the WIC food package. This form does not authorize payment by Medicaid. It must be submitted along with certification of medical necessity for prior authorization of payment.

Participant's Name: _____

Medicaid Number: _____

Diagnosis: _____

Formula Prescribed: _____

Amount of formula per month provided by the WIC Program: _____

Months WIC Provided Formula: _____

Amount of formula needed for the Medical Nutrition Therapy Plan: _____

_____	_____	_____
Signature of Staff	Phone Number	Date

I authorize the WIC program to release the above information.

_____	_____
Signature of Participant/Parent/Guardian	Date

Revised February 2013.