

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