HELPING HANDS™

REIMBURSEMENT SUPPORT

Navigating insurance coverage is not always easy. Through **Helping Hands™ Reimbursement Support,** our team of dedicated reimbursement experts can help guide you through the process from start to finish. From benefits verification to prior authorization assistance, we handle all the details so you can get quick access to Mead Johnson Nutrition products when prescribed.*

We can help with insurance coverage and product access assistance including:

• Medicaid • Medi-Cal • WIC®† • TRICARE®† • Commercial insurance

* Mead Johnson Nutrition products may be eligible for insurance coverage when prescribed. While we can't guarantee insurance reimbursement, our dedicated staff will help you navigate the reimbursement process. Please keep in mind that reimbursement is based on the terms of your insurance contract. Helping Hands™ Reimbursement Support does not reimburse for out-of-pocket expenses including deductibles and co-pays.

† WIC is a registered trademark of the United States Department of Agriculture (USDA) for the Special Supplemental Nutrition Program for Women, Infants, and Children. No endorsement of any brand or product by the USDA is implied or intended. TRICARE is a registered trademark of the Department of Defense, Defense Health Agency.

Mead Johnson™ Nutrition

REIMBURSEMENT SUPPORT

How we lend a helping hand:

Benefit verification: Your dedicated reimbursement expert will coordinate with your healthcare provider and insurance plan to help determine eligibility, coverage requirements, and out-of-pocket costs like deductibles or co-pays.

Prior authorization: If your insurance plan requires prior authorization for coverage, we will determine the process and clinical documentation needed and coordinate with your healthcare provider. If denied, we will help navigate the appeal process.

Consistent and reliable supply: If coverage is available, we'll connect you with a Home Care or Pharmacy Provider who can deliver Mead Johnson Nutrition products right to your door. If coverage isn't available, we'll help assess alternative sources of support.

Get started with three easy steps:

1. Complete patient and healthcare provider sections of the enrollment form.
2. Fax or email completed enrollment form with copy(s) (front and back) of insurance card(s) to:
   - Fax: 855-595-2767
   - Email: support@hhreimbursement.com
3. We'll handle the rest. Your dedicated reimbursement expert will contact you and communicate status updates to you and your healthcare provider along the way until all coverage and product access options are explored.

Questions about Helping Hands™ Reimbursement Support?

Call 855-481-9098, M-F 8 a.m.-8 p.m. ET

For non-reimbursement questions, including product information such as feeding, mixing, storage, nutrition, and current promotions available through Enfamil Family Beginnings®, call 800-BABY123 (800-222-9123), or visit enfamil.com.

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All fields required. Please send completed form to:
Fax: 855-595-2767 or Email: support@hhreimbursement.com
Questions? Call 855-481-9098, M-F 8 a.m.-8 p.m. ET

Enrollment Form | Patient Section:

DEMOGRAPHICS

Patient Name: _____ Date of Birth (DOB): _____ Gender: _____

Street Address: _____ City/State/Zip: _____

Primary Contact Name: _____ Relationship to Patient: _____

Phone #: _____ I give permission to receive text ☐ Y ☐ N

Email: _____ Primary Language Preference: _____

Are you submitting multiple enrollment forms (twins, triplets, etc.)? ☐ Y ☐ N *One form per child required*

INSURANCE INFORMATION

WIC®*: ☐ Yes, enrolled and receiving _____ cans per month† ☐ In process ☐ Not Eligible
† If checked, include WIC letter with enrollment form.

Primary Medical Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ Employer: _____

Rx Group #: _____ Rx BIN #: _____ Rx PCN: _____

Policy Holder Name: _____ Policy Holder DOB: _____ Relationship to Patient: _____

Secondary Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ Employer: _____

Rx Group #: _____ Rx BIN #: _____ Rx PCN: _____

Policy Holder Name: _____ Policy Holder DOB: _____ Relationship to Patient: _____

☐ I completed the entirety of the above insurance section, and I am providing a copy(s) (front and back) of my insurance card(s) and a copy of my WIC letter (if applicable).

☐ I would like to enroll in Enfamil Family Beginnings® (EFB). EFB may provide additional samples, coupons, and information *(read our privacy policy at enfamil.com/privacy-policy)*.

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION

You may choose to enroll in Helping Hands™ Reimbursement Support (Program) that obtains insurance coverage information for Mead Johnson Nutrition products. To enroll you must complete this HIPAA Authorization form (Authorization). Please note that your treatment is not conditioned on signing this Authorization; however, by refusing to sign this Authorization you will not be able to enroll in or receive assistance from the Program.

If you choose to sign this Authorization, you authorize your healthcare provider(s), including your treating provider, referring provider, and your health insurance company (collectively "Providers") to disclose to Mead Johnson Nutrition, the manufacturer of Enfamil Family of Formulas™, its employees, respective affiliates, agents, and contracted third parties (PRO-Spectus, LLC, the administrator of the Program) your protected health information ("Health Information").

Health Information. Health Information includes, but is not limited to, your name and address, health insurance benefits, information about your medical condition, and medical treatments or status.

Purposes. By signing this Authorization, you are authorizing the use and disclosure of your Health Information for the following purposes:

1. Verification of insurance coverage or to support healthcare providers to obtain payment for Mead Johnson Nutrition products.
2. Providing updates regarding the status of your insurance coverage, including reasons for any insurance denial, to you and/or your healthcare provider.
3. Collecting information related to Mead Johnson Nutrition products and communicate with Mead Johnson Nutrition for purposes of treatment, marketing, data collection, research, quality assurance, surveys, and other business activities in connection with the Mead Johnson Nutrition products.

Copy of Authorization. You have the right to receive a copy of this signed Authorization upon request.

Revocation. You may cancel (revoke) this Authorization at any time by notifying the Enfamil® Consumer Resource Center at EnfamilResourceCenter@enfamil.com. Cancellation will not apply to Health Information already disclosed by your Providers to contracted third parties.

Expiration. This Authorization will expire five (5) years from the date this Authorization is signed (unless a shorter period is required by law).

Re-Disclosure. I understand that Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the Program and no longer be protected by federal privacy regulations, including HIPAA.

Patient Name (please print): _____

Patient (Adult) Signature (if applicable): _____ Date: _____

Parent/Legal Guardian Name (please print): _____ Relationship to Patient: _____

Parent/Legal Guardian Signature: _____ Date: _____

Additional Authorized Contact Name (please print): _____

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Enrollment Form | Provider Section:

PRESCRIPTION

Patient Name: _____ Patient Date of Birth (DOB): _____

Provider/Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ RD ☐ Other: _____

Clinic/Facility Name: _____

Street Address: _____

City/State/Zip: _____

Specialty: _____ NPI: _____ Tax ID: _____

Office Contact Name: _____ Title: _____

Phone #: _____ Fax #: _____ Email: _____

! Please include any additional information as required, including but not limited to: growth charts, prior authorization, lab results, office notes, letter of medical necessity, copy(s) (front and back) of patient's insurance card(s), etc.

DIAGNOSIS (list is not all inclusive; denote 1st, 2nd, and 3rd diagnosis/ICD code when applicable)

ALLERGY

- ☐ K52.21 Food protein-induced enterocolitis syndrome
- ☐ K52.22 Food protein-induced enteropathy
- ☐ K52.29 Other allergic and dietetic gastroenteritis and colitis
- ☐ J30.5 Allergic rhinitis due to food allergy
- ☐ L27.2 Atopic dermatitis due to food allergy
- ☐ P54.1 Bloody stool(s) (newborn)
- ☐ K92.1 Bloody stool(s) (non-newborn)
- ☐ K52.82 Eosinophilic colitis
- ☐ K20.0 Eosinophilic esophagitis
- ☐ K52.81 Eosinophilic gastritis / gastroenteritis
- ☐ R62.50 Failure to thrive newborn less than 28 days old
- ☐ R62.51 Failure to thrive (child over 28 days old)
- ☐ P92.6 Failure to thrive (newborn < 28 days old)
- ☐ Z91.011 Allergy to milk products
- ☐ T78.40XA Food allergy
- ☐ K21.9 Gastroesophageal reflux disease
- ☐ K90.9 Intestinal malabsorption
- ☐ K90.4 Malabsorption due to intolerance
- ☐ K91.2 Short bowel syndrome
- ☐ R63.6 Underweight

PREMATURE

- ☐ R62.0 Delayed developmental milestones
- ☐ R62.50 Developmental delay
- ☐ R62.51 Failure to thrive (child over 28 days old)
- ☐ P92.6 Failure to thrive in newborn (< 28 days old)
- ☐ R63.3 Feeding difficulties

OTHER (note here):

☐ _____ ☐ _____ ☐ _____

PRODUCTS (list is not all inclusive)

- ☐ PurAmino™ Infant
- ☐ PurAmino™ Jr Unflavored
- ☐ PurAmino™ Jr Vanilla
- ☐ Nutramigen®: (select type)
  - ☐ powder (with probiotic LGG®) ☐ liquid
- ☐ Nutramigen® with probiotic LGG® Toddler
- ☐ Enfamil NeuroPro™ EnfaCare®: (select type) ☐ powder ☐ liquid
- ☐ Pregestimil®: (select type) ☐ powder ☐ liquid
- ☐ Metabolic (note here): _____
- ☐ Other (note here): _____

DOSING INFORMATION

Amount needed per day: ☐ calories: _____ ☐ fluid ounces: _____ ☐ cans: _____ ☐ other: _____

Days Supply: _____ Refills: _____ Length of need: _____

The above product will provide my patient _____ % of their daily nutritional needs.

Route of administration: ☐ Oral ☐ Tube fed ☐ Bolus ☐ Gravity ☐ Pump

My patient has trialed/failed multiple formulas and requires the above formula to meet their nutritional needs.

Trialed Formula(s): _____

My patient has an identified health condition that prohibits them from trialing other formulas due to the adverse health effects it would illicit.

Prescriber Signature: _____ Date: _____

Mead Johnson Nutrition