

Therapeutic Formula Cover Page

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From: **Name:** _____

Phone: _____ **Email:** _____

LA Name: _____ **LA & Clinic Number:** _____

LA Shipping Address: _____

Pages: _____ **Date:** _____ **WIC Family ID:** _____

Reason: **Please select one:**

Medi-Cal **denials** for therapeutic formula on WIC Card

Request for therapeutic formula **not** on WIC Card

Document(s) included:

Medi-Cal Denial form Medical documentation

Pediatric Referral form Participant Consent form

Comments:

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