BlueCross BlueShield of Delaware

Visit our website at:
http://www.bcbsde.com

Letter of Medical Necessity for Medical Foods and Formula

NOTE: This form may be used as a letter of medical necessity or as a cover sheet to be used when submitting claims for medical foods and formulas.

Patient Name:	Patient Birthday (mm/dd/yyyy):	BCBSD ID Number:
DIAGNOSIS:		

Description of Medical Foods/Formula: (If a formula, please be sure to include the name of the formula, the number of containers and the calories per container.)	Time period approved for the medical foods/formula	
	From (mm/dd/yyyy)	To (mm/dd/yyyy)

I hereby certify that the medical foods and/or formula described above are medically necessary for the dietary treatment of an inherited metabolic disorder.

Physician's Name (Printed)

Physician's Signature

Date (mm/dd/yyyy)

Please send this completed form to the following address:

Blue Cross Blue Shield of Delaware
Attention: Claims Review Department, 1-8-18
PO Box 1991
Wilmington, DE 19899–1991