Washington State WIC Nutrition Program
WIC Medicaid Nutrition Form

Complete the WIC Medicaid Nutrition Form below when requested. You may refer to Process to request Formula from Medicaid to correctly complete the form and learn more about the process. All WIC staff (clerk, certifier, nutritionist, etc.) have authorization to complete this form.

Section 1: Caregiver/Participants Completes the Following

As a WIC caregiver/participant I have read and signed the Release of Information.
Caregiver/participant signature: _____

Section 2: WIC Staff or Medical Provider Completes the Following

1. Patient's name: _____ DOB: _____
2. Caregiver's name: _____ Phone number: _____

Section 3: WIC Staff Complete the Following

1. WIC clinic name and address: _____
2. WIC clinic phone number: _____
3. Is the patient WIC eligible: Yes   No   Decline to State
4. WIC staff name: _____
5. WIC staff signature _____ Date: _____

Section 4: WIC Staff or Medical Provider Completes the Following

1. Requested product name: _____
2. Check the box that applies:

   The requested product isn't WIC approved: WA State WIC Approved Formulas

   The product is available as a WIC Approved Formula. However, the amount prescribed exceeds the maximum monthly allowance.

   Not currently a WIC participant

3. **If the requested formula exceeds the maximum monthly allowance, complete the table below:**

Age	0-3 Months	4- 5 Months	6-11 Months	Child 1-5 Years	Adult
Total cans requested					
Maximum cans WIC allows					
Total cans WIC cannot provide					

Section 5: Optional Additonal Information

1. ProviderOne ID: _____
2. Primary Medical Provider: _____ Phone Number: _____
3. Name of Dietitian (if applicable): _____ Phone Number: _____
4. Is a WIC Nutrition Assessment included: Yes   No