Eat Well, Live Well.

AJINOMOTO CAMBROOKE, INC.
4 Copeland Drive, Ayer, MA 01432

CAMBROOKE™

Facsimile Cover Page

To:	CAMBROOKE*care* Team	**From:**	
Fax:	978 875 8007	**Pages:**	
Phone:	866 383 9455	**Date:**	
Re:	Referral Application	**CC:**	

Complete and fax the following documents:

☐ Referral Application/HIPAA form

☐ Electronic Communication Agreement

If applicable (if patient has one of the insurance company/payers below)

- ☐ **BCBS** Authorization for Release of Information form
- ☐ **United Healthcare** Authorization for Release of Information form

☐ **Copy of front and back of patient's insurance card**

Clinical documents obtained from registered dietitian

- ☐ Prescription
- ☐ Letter of Medical Necessity
- ☐ Clinical/Medical Records

CAMBROOKE*care*™

Referral Application / HIPAA Form

Introduction

CAMBROOKE*care*, a coverage assistance program offered through Ajinomoto Cambrooke, Inc., provides medical formula and food coverage support for patients with inborn errors of metabolism, severe protein allergy, eosinophilic gastrointestinal disorders, intractable epilepsy, and other disorders where ketogenic and gastrointestinal medical nutrition therapy is indicated. If your patient's medical insurance policy or state legislation provides reimbursement for medically necessary medical food products, CAMBROOKE*care*, can provide coverage support and direct billing. Cambrooke does not discriminate or treat patients differently because of race, color, national origin, disability, age, or sex.

All questions contained in this form are strictly confidential and will become part of patient's medical record.

Check One

❑ Medical Formula ❑ Low Protein Foods ❑ Both

Relationship to Patient (check one)

❑ Self ❑ Spouse ❑ Parent ❑ other: _____

Patient Information (please print or type, all fields must be filled in)

_____ *Patient Name*

_____ *Patient Street Address*

_____ *Patient City, State, Zip*

_____ *Patient Contact Number (including area code)*

_____ *Clinic Name*

_____ *Insurance Membership Number*

_____ *Group Number*

_____ *Medical Diagnosis/Inherited Genetic Disorder*

_____ *Date of Birth* _____ *Gender*

_____ *RD/MD Name (no stamps)* _____ *Phone Number*

Subscriber Information (only complete if subscriber is not the patient, e.g. parent)

_____ *Subscriber Name*

_____ *Subscriber Street Address (if different from patient)*

_____ *Subscriber City, State, Zip (if different from patient)*

_____ *Subscriber Contact Number (including area code) (if different)*

_____ *Subscriber Insurance Name*

_____ *Subscriber Insurance Phone Number (back of card)*

_____ *Employer's Address (if known)*

_____ *Subscriber email address*

Secondary Subscriber Information

_____ *Subscriber Name*

_____ *Subscriber Street Address (if different from patient)*

_____ *Subscriber City, State, Zip (if different from patient)*

_____ *Subscriber Contact Number (including area code) (if different)*

_____ *Subscriber Insurance Name*

_____ *Subscriber Insurance Phone Number (back of card)*

_____ *Employer's Address (if known)*

_____ *Subscriber email address*

Assignment of Insurance Benefits & Right of Recovery

In consideration of medically authorized low protein food and/or formula products provided, I hereby irrevocably assign and transfer to Ajinomoto Cambrooke, Inc. all rights, title and interest in the benefits payable for such foods, provided in the above mentioned policy(ies) of insurance. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance but shall not be construed to be an obligation of Ajinomoto Cambrooke, Inc. to pursue any such right of recovery. Provided however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by an insurance carrier(s). I hereby authorize the insurance company(ies) herein listed above to pay directly to Ajinomoto Cambrooke all benefits due under said policy(ies) by reason of product provided therein. **If full payment is not received within 90 days of billing your insurance provider, payment options must be negotiated with Ajinomoto Cambrooke. Co-payment, co-insurance, and deductibles (for example, if you pay 20% and your insurance provider pays 80%) will be charged directly to your credit card per policy agreement (you will supply valid major credit card information when you place your order).** You will be notified by electronic mail or letter that will also include your receipt. Duplicate payments by your insurance provider to Ajinomoto Cambrooke for any paid claim will be refunded to you. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient or Responsible Party Signature ➔ _____ *Date* _____

Authorization Expiration and Revocation

I hereby request and authorize Ajinomoto Cambrooke, Inc to release and receive my personal health information (PHI), maintained by my ordering clinician(s), as necessary, to assist in eligibility and benefit verification and to process insurance claims, insurance applications and the fulfillment of prescriptions.

This authorization will expire (1) one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to Ajinomoto Cambrooke, Inc. However, revocation of this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization. If I do not sign, I can still receive my medication but Cambrooke will not be able to provide assistance with eligibility and benefit verification, processing of insurance claims, insurance applications and the fulfillment of prescriptions.
- Federal privacy regulations will no longer apply to the information disclosed and that Ajinomoto Cambrooke, Inc. may re-disclose this information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Responsible Party Signature ➔ _____ _____ *Date*

_____ *Name of Representative* _____ *Relationship to Patient*

CAMBROOKEcare™

Electronic Communication Agreement

Electronic communications at Ajinomoto Cambrooke include email and text messages.

Electronic communications containing PHI (protected health information) between Ajinomoto Cambrooke and the patient/authorized representative may be used if you, the patient/authorized representative, agree to this method and complete and sign this form.

This agreement is limited to communications using the email address and/or phone number you authorize below. You can change or withdraw your authorization any time by completing the appropriate form. This completed agreement replaces any prior agreement effective the date it is received.

Provider Awareness:
Standard email and text is not a secure means of communication. As your healthcare providers, Ajinomoto Cambrooke will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you. Unsecure electronic communications will not include highly sensitive PHI (such as information relating to mental health or substance abuse).

Patient Awareness:
Standard email and text do not provide a secure means of communication. There is some risk that PHI within the unsecure electronic communication may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax, are always available alternative methods of communication with Ajinomoto Cambrooke.

- Emails originating from Ajinomoto Cambrooke will be sent from the domain @cambrooke.com
- Text messages originating from Ajinomoto Cambrooke will indicate that Ajinomoto Cambrooke sent the message

By completing this form, I, the patient/authorized representative, understand and accept the risks involved with unsecure electronic communications containing protected health information between myself and Ajinomoto Cambrooke, and I hereby authorize Ajinomoto Cambrooke to send such electronic communications.

Patient Name _____ Date of Birth _____

Authorized Representative (if applicable) _____ Relationship to Patient _____

Home Phone Number _____

Cell Phone Number (to receive text messages) _____

Email Address (to receive emails) _____

Indicate Preferred Method of Contact:
(check one)

- ☐ Home Phone Number
- ☐ Cell Phone Number — Phone Call
- ☐ Cell Phone Number — Text Message
- ☐ Email Address

Patient/Authorized Representative Signature ↑ _____ Date _____

Send completed form to:

Ajinomoto Cambrooke
4 Copeland Drive
Ayer, MA 01432

Fax: 978 875 8007
Email: reimbursement@cambrooke.com

BCBS Member's Authorization for Release of Information

Please use this form to authorize Blue Cross and Blue Shield to send specific information to a specific person for a specific time, when that release is not otherwise allowed by law. Use of this form does not provide the recipient with unlimited access to the Member's information.

The member named below should be the person signing this authorization and requesting the release of information. If the member is a minor, a parent or legal guardian must sign. If the member is unable to sign for any other reason, a legal representative must sign the authorization and submit documentation to verify the authority to sign.

Member's Name: _____ Member's ID#: _____ Date of Birth: _____

Address: _____ Daytime Phone Number: _____

I authorize BCBS to disclose claims and medical information in its files as follows:

You must circle one answer for each option listed (circle "No" if not applicable)

I authorize release … of these records:

Yes (No) HIV testing and/or AIDS diagnosis or treatment

Yes (No) Mental health

(As directed:) Release any and all information related to my care to Ajinomoto Cambrooke, Inc. with regards to my eligibility, medical benefits, medical claims, co-payments, deductibles and claims as necessary.

Name of person or entity to receive information: Ajinomoto Cambrooke, Inc
Attn: Accounts Receivables
Address: 4 Copeland Drive, Ayer, MA 01432

This authorization expires one (1) year from the date of signature. It is completed at my own request and is not a condition of enrollment or benefits. I may revoke this authorization at any time by notifying BCBS in writing. I understand that a revocation will not apply to information already released while this authorization was in effect. I understand that once information has been released according to these instructions, BCBS will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information. I may receive a copy of this authorization and agree that a photocopy is as valid as the original.

Signature: _____ Print name: _____ Date: _____

If not the member, please state your relationship to the member (for example, "parent") here: _____

United Healthcare Designation of Authorized Representative

MEMBER INFORMATION (Required) *(Please print)*

Member ID number

Member date of birth

Member first name *Member middle initial* *Member last name*

Member permanent address *City* *State* *Zip code*

Daytime phone number (including area code)

Evening phone number (including area code)

DESIGNATED REPRESENTATIVE

AJINOMOTO CAMBROOKE, INC.

Name

ATTN ACCOUNTS RECEIVABLES, 4 COPELAND DRIVE, AYER MA 01432

Address

YOUR PERMISSION (Required)

I do hereby name Ajinomoto Cambrooke, Inc. to act as my authorized representative in requesting a complaint, an appeal or documents from United Healthcare.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Sign Here: _____ Print Name:_____ Date: _____

If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative):

_____

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority.