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

Eat Well, Live Well.
AJINOMOTO

Facsimile Cover Page

To:	CAMBROOKEcare 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
- ☐ Copy front/back patient's insurance card
- ☐ Prescription
- ☐ Letter of Medical Necessity
- ☐ Clinicals/Medical Records

If applicable:

- ☐ CMS 1500 *(if Cambrooke Therapeutics is direct billing)*
- ☐ BCBS Authorization for Release of Information form *(if patient has BCBS)*
- ☐ United Healthcare Designation of Authorized Representative form *(if patient has UHC)*

CAMBROOKE*care*™

Referral Application / HIPAA form

Introduction

CAMBROOKE*care*, a coverage assistance program offered through Cambrooke Therapeutics, Inc., provides medical formula and food coverage support for patients with inborn errors of metabolism, intractable epilepsy, and other disorders where ketogenic 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*

_____ *Insurance Membership Number*

_____ *Patient Street Address*

_____ *Group Number*

_____ *Patient City, State, Zip*

_____ *Inherited Genetic Disorder*

_____ *Patient Contact Number (including area code)*

_____ *Date of Birth*

_____ *Gender*

_____ *Clinic Name*

_____ *RD/MD Name (no stamps)*

_____ *Phone Number*

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

_____ *Subscriber Name*

_____ *Subscriber Insurance Name*

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

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

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

_____ *Employer's Address (if known)*

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

_____ *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 Cambrooke Therapeutics, 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 Cambrooke Therapeutics, 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 Cambrooke Therapeutics 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 Cambrooke Therapeutics. 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 Cambrooke Therapeutics 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 Cambrooke Therapeutics, 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 Cambrooke Therapeutics, 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.
- Federal privacy regulations will no longer apply to the information disclosed and that Cambrooke Therapeutics, 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*

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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 Cambrooke Therapeutics, 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: Cambrooke Therapeutics, 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

CAMBROOKE THERAPEUTICS, INC.

Name

ATTN ACCOUNTS RECEIVABLES, 4 COPELAND DRIVE, AYER MA 01432

Address

YOUR PERMISSION (Required)

I do hereby name CAMBROOKE THERAPEUTICS, 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.