



**Special Exception Request for CMS Coverage of Low Protein Modified Foods**

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ CMS Area Office: \_\_\_\_\_

***This section must be signed the licensed treating physician:***

Treating Physician Name (Printed): \_\_\_\_\_

National Provider ID: \_\_\_\_\_

Physician Type/Specialty: \_\_\_\_\_

Diagnosis Code for Low Protein Modified Foods **(Please check one):**

	<u>ICD-9</u>	<u>ICD-10</u>
<input type="radio"/> PKU	271.1	E70.0
<input type="radio"/> Tyrosinemia	270.2	E70.21
<input type="radio"/> MSUD	270.3	E71.0
<input type="radio"/> Urea Cycle Disorder	270.6	E72.4
<input type="radio"/> Propionic Acidemia	270.3	E71.121
<input type="radio"/> Methylmalonic academia	270.3	E71.120
<input type="radio"/> Homocystinuria	270.4	E72.11

Expected Frequency/Duration of Treatment: \_\_\_\_\_

Is the request proved effective: **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Physician

Comments: \_\_\_\_\_

\_\_\_\_\_

**Treating Physician's Signature and Credentials:**

\_\_\_\_\_ License #: \_\_\_\_\_

Date: \_\_\_\_\_

**Please attach all related medical records and fax to 850-921-5241**