CAMBROOKE*care*™

new possibilities…everyday

CAMBROOKE*care* provides you with expanded reimbursement and coverage assistance you need today. This is a full service program designed for one very important thing: helping you to manage your family's medical food coverage and reimbursement options.

At a time when there are so many paths for medical foods coverage, CAMBROOKE*care* gives you the flexibility, choice, coverage support, and reimbursement options when managing your family's needs.

CAMBROOKE*care* is available to anyone needing assistance with:

- ketogenic formula coverage support
- low protein food coverage support
- metabolic formula coverage support
- severe protein allergy formula coverage support
- eosinophilic gastrointestinal disorder formula coverage support
- coverage assistance support services
- co-pay assistance
- coding and billing information for patients and healthcare providers
- insurance direct billing services
- supplier sourcing (pharmacy, durable medical equipment [DME], etc...)

GET AN **ANSWER** RIGHT AWAY!

833-999-1462

cambrookecare@nexuspatientservices.com

GET **STARTED** TODAY!

CAMBROOKE*care*™ is a full service coverage and reimbursement assistance program offered through Ajinomoto Cambrooke, Inc.

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do you have questions?

LET US HELP!

The CAMBROOKE*care* support team is highly trained in all aspects of medical foods coverage and reimbursement support.

We can help with:

- new patient set up
- connecting with insurance companies
- direct billing services
- food and formula supplier options (pharmacy, DME, etc…)
- reimbursement and coverage problems
- and more…

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Referral Application / HIPAA Form

Introduction

CAMBROOKE*care*, a coverage assistance program offered through Ajinomoto Cambrooke, Inc. partner Nexus Patient Services, 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 | *Insurance Membership Number*

Patient Street Address | *Group Number* *RxBin* *PCN*

Patient City, State, Zip | *Medical Diagnosis/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) Include a picture of insurance card (front/back)

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*

Secondary Insurance Information

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 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 origin

Patient or Responsible Party Signature ☐ _____ *Date* _____

Authorization Expiration and Revocation

I hereby request and authorize Ajinomoto Cambrooke, Inc, or its partner Nexus Patient Services to release and receive my personal health information (PHI), maintained by my ordering clinician(s), as necessary, to assist ineligibility 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 ☐ _____ _____

Name of Representative *Date*

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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:

CambrookeCare
Nexus Patient Services
5080 N 40th Street, Ste 300
Phoenix, AZ 85018

Fax: 877-765-7704
Email: cambrookecare@nexuspatientservices.com