



Aevitae

P.O. Box 2705

6401 DE Heerlen

## Declaration of Nutritional Preparations

### Details of insured person

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

Date of birth: \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

BSN (Social Security Number): \_\_\_\_\_

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

Postal code and town/city: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

### Prescriber's details

Prescriber's name: \_\_\_\_\_

Name of institution/practice: \_\_\_\_\_

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

Prescriber's AGB code: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

### A. Assessment of eligibility

As prescriber, I wish to prescribe a polymer, oligomer, monomer or modular nutritional preparation:

Indication Cross the answer that applies		Supply at cost of health insurance approved yes/no		
1. Can the insured person manage with modified ordinary nutrition?	→	<input type="radio"/> Yes, this is possible	→	Supply at cost of health insurer NOT approved
	→	<input type="radio"/> No, that is not possible	→	Go to question 2
2. Can the insured person manage with other special nutrition products?	→	<input type="radio"/> yes, this is possible	→	Supply at cost of health insurer NOT approved
	→	<input type="radio"/> No, that is not possible	→	Go to question 3

### 3 Indicate with a cross what is applicable:

3a. The insured person suffers from a digestive disorder	→	Go to part B of this form
3b. The insured person suffers from a food allergy	→	Go to part B of this form
3c. The insured person suffers from an absorption disorder	→	Go to part B of this form
3d. The insured person suffers from illness-related malnutrition, or a risk of it, established via a validated screening instrument	→	Go to part B of this form
3e. The insured person, in accordance with the guidelines accepted in the Netherlands by the appropriate professional groups, needs a polymer, oligomer, monomer or modular nutritional preparation	→	Go to part B of this form
3f. The insured person does not suffer from any of the indications listed above	→	Supply at cost of health insurer NOT approved

**B. Product and dose**

Type of nutrition preparation(s)

Dose (for example number of bottles, millimetres or grams per day)


**C. Treatment objective (including expected duration of use)**


**D. Determination of the period**

Type of application and indication	Applicable answer to be crossed by prescriber	Period
4. This is the first application for indication 3b, 3c, 3d or 3e	<input type="radio"/> Yes	One month at health insurer's cost
	<input type="radio"/> No	Go to question 5
5. This is a first or extension application for indication 3a	<input type="radio"/> Yes	<input type="radio"/> One month at health insurer's cost <input type="radio"/> Three months at health insurer's cost <input type="radio"/> Six months at health insurer's cost <input type="radio"/> Twelve months at health insurer's cost
	<input type="radio"/> No	Go to question 6
6. This is an extension application for indication 3b, 3c, 3d or 3e	<input type="radio"/> Yes	<input type="radio"/> One month at health insurer's cost <input type="radio"/> Three months at health insurer's cost <input type="radio"/> Six months at health insurer's cost <input type="radio"/> Twelve months at health insurer's cost

**This declaration has been completed truthfully by the prescriber:**

Date form issued:

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Prescriber's signature:

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**To be completed by supplier:**

Supplied at cost of health insurer:

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Supplier's signature:

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This form is intended for the contracted supplier or pharmacy and should not be sent to the health insurer, unless the insured person opts for a non-contracted care provider. Then you should send the Declaration for Nutritional Preparations straight to Aevitae. You can find the contracted care providers for the supply of nutritional preparations on our website.

**Explanation to prescriber for completion of the declaration for nutritional preparations**

Below you can find an explanation for the prescriber for completing the Declaration for Nutritional Preparations.

You should apply for permission in advance from the insured person before supplying information to contracted suppliers. If the insured person does not want to provide the information to the supplier (for example for privacy considerations) you may alternatively send the form directly to us. Please see the insurance conditions or our website for the address.

Declaration part	Additional explanation
Details of insured person	Please enter the insured person's full details. If the insured person does not have an e-mail address, this field does not have to be completed.
Prescriber's details	Enter your full details.
A. Assessment of eligibility	Here you mark the applicable answer to questions 1, 2 and 3 with a cross.
B. Product en dosering	Here you enter the type of nutritional preparation(s). Additionally, you indicate what the dose is. Example: 2 bottles of 200 mL per day.
C. Treatment objective (including expected duration of use)	Here you indicate what you intend to achieve through treatment of the insured person using the nutritional preparation(s). Additionally, you indicate how long you expect the insured person to have to use the preparation.  Example: In Field B you have entered for Type of nutritional preparation: Energy-enriched liquid nutrition on milk basis, flavour strawberry - coffee - banana. Dose: Twice a day one bottle of 200 ml. Treatment objective: weight maintenance. Expected duration of use 3 months.
D. Determination of the period	You enter here whether it is a first or an extension application.
Date of issue and signature	Here you enter the date on which you send the Declaration for Nutritional Preparations to the supplier of nutritional preparations. Then you sign the form.