



DIRECT BILL FOR WIC-ELIGIBLE NUTRITIONALS AND THERAPEUTIC FORMULA

This form replaces WIC checks and must be completed and signed by a WIC Registered Dietitian.

Clinic No.

First Day to Use:

Last Day to Use:

Responsible Adult

is authorized to receive the following special nutritional supplement for

Participant Name

ID #

Age

Category

% Breastfeeding

Quantity
(please specify cans, oz, 4-pk, etc.)

Full Nutrition Benefit /
Maximum Monthly Allowance
(WIC RD use only)

Therapeutic Formula / Nutritionals

Need for product must be evaluated monthly.

Registered Dietitian

Vendor Name

Address

City

Zip Code

I verify that the information listed above is correct to receive and/or order special nutritional supplement(s).

Responsible Adult Signature

Date

VENDOR – Please send this form with an invoice and/or register tape showing product, amount and price to:

**Idaho WIC Program
Department of Health & Welfare
P.O. Box 83720
Boise, ID 83720-0036**

Reimbursement will not be made unless a completed copy of this form is included with the invoice.

WIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at

www.wic.dhw.idaho.gov.