Nature's One®

Medical Hardship Discount Program

Please Fax Completed Form to 740-548-3879 **or** Mail to:
Nature's One Medical Hardship Program 8754 Cotter St. Lewis Center, OH 43035

Parent or Guardian Information

Parent/Guardian Name: _____

Home Address: _____

City: _____ State or Province: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Child's Information

Child's Name: _____

Date of Birth: _____ Child's Gender: ☐ Male ☐ Female

For Doctor to Complete

Date of Diagnosis: _____ Product Use: ☐ Oral ☐ Enteral

Describe diagnosis: _____

☐ Autism ☐ Cerebral Palsy ☐ Eating Disorders
☐ Cancer ☐ Cystic Fibrosis ☐ Metabolic Disorder
☐ Celiac Disease ☐ Down Syndrome ☐ Other _____

Doctor's Name: _____ Doctor's Address: _____

City: _____ State or Province: _____ Zip Code: _____

Doctor's Phone: _____ Doctor's Fax: _____

Doctor's Signature: _____ **Date:** _____

Nature's One® Hardship Policy Agreement

- For customers who do not qualify for Medicare/Medicaid or private insurance coverage, Nature's One® offers a 30% Medical Hardship Discount for children with the following chronic condition for which a Nature's One® product has been deemed appropriate by my child's healthcare professional: Autism, Cancer, Celiac Disease, Cerebral Palsy, Eating Disorders, Cystic Fibrosis, Down Syndrome, Metabolic Disorders or other nutrition related, medically diagnosed condition.
- Products discounted by Nature's One® may only be consumed by the child enrolled in the Medical Hardship Discount Program. This discount cannot be combined with any other coupons or discount offers.
- Infractions to these policies are grounds for discontinuation of the Medical Hardship Discounts.
- The privacy of all medical information will be protected and held confidential by Nature's One.®

Each application will be evaluated by Nature's One® healthcare professional staff on an individual basis. Enrollment approval will be based upon the committee's final decision.

I AGREE WITH THE TERMS OF NATURE'S ONE® MEDICAL HARDSHIP DISCOUNT PROGRAM.

Parent/Guardian Signature: _____ Date: _____