

Special Formula Replacement Request Form

WIC – 397

Purpose: To allow local sites replacement of ordered special formula from the CAP Distribution Center. The Damaged Report (WIC-394) must be submitted with this form.

Reference: FDS 03.2.2

Procedure: Complete the WIC-397 Special Order Replacement Form as follows:

1. **Replacement Order Date** – Enter the date the replacement order is sent to the Distribution Center.
2. **Original Order Date** – Enter the date the original order is sent to the Distribution Center.
3. **Clinic ID Number (4–6 digit)** – Enter the state assigned local agency site (4 digit) number.
4. **Local Agency / Clinic Name** – Enter the local agency site name ordering the special formula.
5. **Participant Name, Participant ID** – Enter the participant name and ID as listed on the WIC food benefits issuance.
6. **Contact Person** – Enter the name of the site contact person who will be able to answer questions concerning the order.
7. **Phone Number** – Enter the local agency site telephone number (including area code). This information is required in case a problem should arise.
8. **Fax Number** – Enter the local agency site fax machine number (including area code). This information is required in case a problem should arise.
9. **Email Address** – Enter the local agency contact person VDH email address. This information is required in case a problem should arise.
10. **Shipping Name** – Enter the name of client name, parent/guardian name.
11. **Shipping Address** – Enter the client or local agency address. **Do not use address stamps.**
12. **Local Agency / Participant Home** – Place an “X” in the appropriate field for the ship to location.
13. **Product Name** – Enter the product name as listed on the WIC food benefits issuance.
14. **Conc., RTF, PWD or Pudding** – Enter the form of the product, concentrate, ready-to-feed, powder, etc....
15. **Quantity** – Enter the quantity to be replaced. **The quantity can not exceed the quantity specified on the original food benefits issuance.**
16. **Container Size** – Enter the appropriate container size for the prescribed food package.

17. **Flavor Packet Type** – Enter the flavor packet to be provided, manufactured and available from the formula distribution center.

18. **Food Instrument Number** – Enter the original #396 Request Order Form food benefit issuance.

REQUEST FOR **REPLACEMENT** OF SPECIAL FORMULA

Replacement Order Date: _____
 Original Order Date: _____

**ALWAYS CALL THE FORMULA DISTRIBUTION CENTER BEFORE PLACING A REQUEST FOR REPLACEMENT
 TEL. 717-293-0187 EXT. 0**

<u>Participant and Local Agency Information</u>	<u>Shipping Information</u>
Clinic ID Number (4-6 digit): <u>VA</u> Local Agency/Clinic Name: _____ Participant Name: _____ Participant ID #: _____ <small>(Including suffix)</small> Contact Person: _____ Phone Number: _____ Fax Number: _____ Email Address: _____	Name: _____ <small style="text-align: center;">CLINIC NAME OR PARENT/GUARDIAN NAME ONLY</small> Address: _____ _____ City: _____ State: _____ Zip: _____ <input type="checkbox"/> Local Agency <input type="checkbox"/> Participant Home
<u>Reason for Replacement: (Required)</u>	

Product Name	Conc., RTF, PWD or Pudding	Quantity	Container Size	Flavor Packet Type	Flavor
Virginia WIC - one FI per replacement order	XXXXXXXXXX	XXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXXX

Original Food Instrument Number(s): _____

For Warehouse Use Only

