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.

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## REQUEST FOR REPLACEMENT OF SPECIAL FORMULA

**Participant and Local Agency Information**
- **Clinic ID Number (4-6 digit):** VA
- **Local Agency/Clinic Name:**
- **Participant Name:**
- **Participant ID #:** (Including suffix)
- **Contact Person:**
- **Phone Number:**
- **Fax Number:**
- **Email Address:**

**Shipping Information**
- **Name:**
- **Address:**
- **City:**
- **State:**
- **Zip:**
- **Local Agency**
- **Participant Home**

**Reason for Replacement:** (Required)

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Conc., RTF, PWD or Pudding</th>
<th>Quantity</th>
<th>Container Size</th>
<th>Flavor Packet Type</th>
<th>Flavor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia WIC - one FI per replacement order</td>
<td>XXXXXXXXXX</td>
<td>XXXXX</td>
<td>XXXXXXXXXX</td>
<td>XXXXXXXXXX</td>
<td>XXXXXXXXXX</td>
</tr>
</tbody>
</table>

**Original Food Instrument Number(s):**

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For Warehouse Use Only