



Providence Home Medical Equipment (PHME)
WIC Special Medical Formula Request



Order Date: _____ Voucher Issuance Month: _____

Participant's Name: _____
(Last , First , MI)

Parent/Guardian Name _____ Phone #: _____
(Last , First , MI)

WIC Voucher #: _____ WIC ID#: _____

Prescribed Formula: _____ Quantity: _____

Powder Concentrate Ready-to-feed Other:

Flavored: Yes No If yes, flavor name: _____ Fiber (check one): With Without

Instructions for Providence HME (check one):

- Client will pick up
- Mail to client
- Mail to WIC clinic - Attn: WIC contact (see below)
- Mail to parent/guardian

Voucher and order form have been checked for accuracy.

Formula Mailing Address (street addresses only):

Street address _____ Apt # _____

City _____ State _____ Zip _____

Special Instructions: _____

WIC Local Agency: _____

WIC Contact Name 1: _____ Phone: _____
Email 1: _____

WIC Contact Name 2: _____ Phone: _____
Email 2: _____

Mail signed voucher for one month only to Providence once the order form has been faxed.

Mail voucher to:
Providence Home Medical Equipment
Attn: Halsey Store Front
6410 NE Halsey St, Ste 500
Portland, OR 97213

WIC voucher mailed to Providence on (date): _____

Email: WIC@providence.org

FAX: (503) 215-4424

Attn: Halsey Store Front / Referral Intake – Providence Home Medical Equipment