STEP 1: PATIENT INFORMATION

Full Name (First, Last): _____ DOB: ____/____/____ Gender: ☐ F ☐M

Phone #: _____ Email: _____

Check off any special needs that apply: ☐ Vision ☐Hearing ☐Language ☐Cognitive ☐Physical ☐ Other (specify): _____

STEP 2: HEALTH INSURANCE INFORMATION

Plan Name: _____ Member ID: _____ Group #: _____ Provider Phone #:_____

Policy Holder Full Name: _____ Policy Holder DOB: _____ Relationship:☐Self ☐Spouse ☐ Child ☐Other

STEP 3: SERVICES   *This referral has both Medical Nutrition Therapy (MNT) & Diabetes Self-Management Education (DSME) CPT codes attached. Check off ANY/ALL additional services needed*

<u>Monitoring</u>: ☐Continuous Glucose Monitor (CGM) Education   ☐Remote Patient Monitoring (RPM) &/or Chronic Care Management (CCM)
<u>Coaching</u>: ☐Personal Trainer   ☐Weight Loss Coach   ☐Lifestyle/Health/Behavioral Coach   ☐Pre & Post Insulin Pump
<u>Mental Health:</u> ☐Diabetes Distress & Burnout   ☐Chronic Disease Management   ☐Anxiety/Depression   ☐Trauma
<u>Specific Concerns:</u> _____

STEP 4: ICD CODES   *Insurance often needs a preventive & medical ICD-10 code for MNT coverage.* ☑ *Check off <u>ALL</u> that apply*

<u>Preventative - Weight:</u> ☐ Underweight (BMI <18.5) ☐ Overweight (BMI 25-29)   ☐Obese (BMI 30-39)   ☐Morbid Obese (BMI 40+)
<u>Preventative - Family Hx:</u> ☐Ischemic Heart Disease & Other Disease of the Circulatory System: Z82.49   ☐ Family History of Diabetes Mellitus: Z83.3
<u>Preventative - Other:</u> ☐Hypertension: I10 ☐Hypercholesterolemia: E78   ☐Hyperlipidemia: E78.5   ☐Metabolic Syndrome: E88.81
<u>Medical - Diabetes:</u>   ☐Type 1: E10.65   ☐Type 2: E11.65   ☐Pre-Diabetes: R73.03   ☐ Gestational: O24.41 ☐ Impaired Glucose Fasting: R73.01
<u>Other (please specify):</u> ☐_____

STEP 5: REFERRING PHYSICIAN'S SIGNATURE   *For the first patient referred to us by this physician, please provide the NPI, phone number, and fax number for our records.*

Full Name (First, Last): _____ NPI: _____ Date of Referral: _____

Physician's Signature: _____ Phone #: _____ Fax #: _____

STEP 6: FAX REFERRAL ALONG WITH ADDITIONAL DOCUMENTATION TO 1-800-782-6249

- Patient Demographics to include address
- Primary and Secondary insurance details (if applicable). Copy of front and back of card is preferred.
- Clinical data such as diagnosis, recent lab results, height, weight, medication list, and any other necessary information for care.