PATIENT REFERRAL FOR MEDICAL NUTRITION THERAPY

FAX THIS FORM TO: CONTEMPORARY NUTRITION

Morehead City 252-648-8087 New Bern 252-631-5223

1) Fax us this form
2) We contact the insurance company to verify coverage and benefits for the patient.
3) We contact the patient to schedule the time and office location that best fits their needs.

Please contact our office with any questions: 648-8777 Morehead City ● 631-5222 New Bern

Date of Referral _____ Phone # _____

Referring Provider _____ Fax # _____

Provider NPI _____ Email _____

Patient Information

Patient's Full Name _____ Home # _____

Address _____ Cell # _____

_____ Work # _____

Patient's DOB _____ Email _____

Insurance Information **(Please list or attach a copy of the front and back of patient insurance card)**

Primary Insurance Company Name _____ Secondary Insurance Company _____

Patient Policy # _____ Patient Policy # _____

Insurance Contact # _____ Insurance Contact # _____

Referral Information **(Please list or attach copy of patient's medical history and any recent labs)**

Referral Dx #1 _____ Other Major Medical Hx _____

Referral Dx #2 _____ Other Major Medical Hx _____

Referral Dx #3 _____ Other Major Medical Hx _____

_____

****PROVIDER'S SIGNATURE****

OFFICE USE ONLY:

Date: _____ Time: _____ Representative: _____

Benefit Period: _____ to _____

Does this policy have MNT Benefits? CPT Codes (97802, 97803, 97804) Y N

Is this benefit limited to a specific diagnosis or co-morbidity? _____

Is there a Physician referral needed? Y N _____

In-Network

Limit to the # of visits: _____

Limit to the # of units: _____

Deductible applies: _____

Copay / Coinsurance: _____

Out-of-Network _____ No benefit

Limit to the # of visits: _____

Limit to the # of units: _____

Deductible applies: _____

Copay / Coinsurance: _____

Notes: _____

Reference _____