Rhode Island Hospital
A Lifespan Partner

MEDICAL NUTRITION THERAPY REFERRAL Date: ____/____/____

Patient Name: _____ D.O.B.: _____
Last, First, Middle Initial

_____
Address City State Zip Code

_____
Home Phone Cell Phone

Primary Language: _____ Interpreter Required Yes: □ No: □

Referring Physician: _____
Signature NPI #

Group Practice: _____
Name Address

_____
Telephone # Fax # Contact Person Contact Person Direct Line

Insurance: *(Include policy number below. Check all that apply)*:

□ NHPRI RIte Care	□ BCBSRI Product: _____	□ Cigna	□ Katie Beckett
□ UHPNE RIte Care	□ BlueChip	□ HealthNet	□ No Coverage
□ Tufts	□ BlueChip RIte Care	□ Medicaid/SSI- Rhode Island	□ Other Insurer/Info (policy/auth #)
□ Harvard Pilgrim	□ Health Mate Coast to Coast	□ Medicaid/SSI- Massachusetts	_____
□ Aetna		□ ***Medicare (see below)***	

NON-MEDICARE: Policy Number: _____ Guarantor: _____ Guarantor DOB: _____
Referral Number: _____Number of Visits: _____ Expiration Date: _____ **Please check with insurance plan prior to referring patient for nutrition counseling to verify patient's plan covers nutrition visits. Insurance coverage varies based on individualized plans.**

STOP **MEDICARE** PATIENTS ARE ONLY COVERED FOR DIAGNOSES OF ***DIABETES OR RENAL DISEASE***. FOR ALL OTHER DIAGNOSES, INCLUDING OBESITY AND PREDIABETES, NUTRITION COUNSELING MUST BE DONE BY THE MEDICAL PROVIDER IN AN OFFICE VISIT. FOR DIABETES THE PHYSICIAN **MUST PROVIDE DOCUMENTATION** WITH THIS REFERRAL OF DIABETES BASED ON ONE OF THE FOLLOWING:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

MEDICARE Medical Nutrition Therapy (MNT):

□ Initial MNT □ 3 hours in one calendar year
□ Annual follow-up MNT □ 2 hours in one calendar year
□ _____ additional hrs requested for a change in medical condition, treatment, and/or diagnosis (specify below):
_____

Reason for Referral (Specify the ICD-10 Diagnosis – check all that apply):

□ Abnormal Glucose (Other) (Not covered by Medicare)	R73.09	□ Dermatitis due to ingested food	L27.2	□ Metabolic Syndrome	G88.81
□ Abnormal Wt Gain	R63.5	□ Gastrointestinal Food Allergy	K52.2	□ Nutritional deficiency, unspecified There are codes for individual nutrient deficiencies	E63.9
□ Abnormal Wt Loss	R63.4	□ Hypercholesterolemia	E78.0	□ Obesity (Unspecified)/Overweight	E66.9
□ ***CKD, stage 3 (moderate)***	***N18.3***	□ Hyperlipidemia, Mixed	E78.2	□ Obesity (morbid/severe)	E66.01
□ ***CKD, stage 4 (severe)***	***N18.4***	□ Hyperglyceridemia	E78.1	□ Underweight	R63.6
□ ***DM Type 2 or unspecified***	***E11.9***	□ Impaired Glucose Tolerance	R73.02	□ Other (Specify **ICD-10** code):	
□ ***DM, Type 1, w/o complications***	***E10.9***	□ Iron deficiency anemia, unspecified	D50.9		
□ Elevated BP w/o HTN	R03.0	□ Irritable bowel synd w/ diarrhea	K58.0		
□ Essential (Primary) HTN	I10	□ Irritable bowel synd w/o diarrhea	K58.9		
□ Failure to Thrive – Adult	R62.7	□ Malnutrition	E46		

Additional Information: _____

Please fax referral to (401)444-6360