Physician referral form for MNT services

Form to be completed by the physician and faxed/sent to:

Deborah L Kimble, LD, CDE, MSPH
4851 Lakeshore Dr., St. Cloud, FL 34772
fax 407-957-1186

Medical Nutrition Therapy
CPT code 97802 initial visit
97804 group

provider # 620128 BC/BS, Health Options PPO
provider # E7736 Medicare (StayWell, WellCare preauthorization fax# 877-431-8859)
provider # not necessary United Health Care, Aetna, United American Ins Co
{*Beechstreet, American Specialty Health, AvMed pending*}

Patient's name:____

Address:____

Phone:____

Primary insurance:____

Policy ID #:____________________________ / Authorization approval #_____________

Phone:________________________________

Diagnosis code: __ __ __. __ __

Please attach lab results supporting diagnosis.________

Order: Provide Medical Nutrition Therapy
Physician information:
(Written signature and date)

_____________________________________ date: _______________________________

UPIN: ___________________ Physician fax:______________________________

Name:___________________ Address:____

I will call the patient and set up an appointment. I make home visits.
Thank you for the referral.

2/8/02