

Provider NPI:  
Group NPI:  
EIN:

## Verification of Nutrition Benefits

Patient's Name: \_\_\_\_\_

Patient's Date of birth: \_\_\_\_\_

Home Address : Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_

Applicable ICD 10 codes:  
\_\_\_\_\_

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Date: \_\_\_\_\_ Time: \_\_\_\_\_ Representative: \_\_\_\_\_

Policy type: PPO HMO POS Other \_\_\_\_\_

Benefit period: From \_\_\_\_\_ To \_\_\_\_\_

Is this a FULLY funded plan? Yes No Is this a SELF-funded plan? Yes No

Is this policy a grandfathered plan not needing to adhere the Affordable Care Act? Yes No

Does this policy have Nutrition Counseling/Medical Nutrition Therapy Benefits? Yes No

Which CPT codes are covered on this policy? 97802 97803 97804 S9470 99401-99404

Are BOTH preventative nutrition services covered under Health Care Reform AND medical benefits covered? Yes No

Does this plan cover telehealth services? Yes No

Is there a co-pay for telehealth services Yes No Amount \$ \_\_\_\_\_

Does this plan require an MD referral Yes No

Does this plan require prior authorization for nutrition services Yes No Comments

Does this plan require the dietitian submit medical documentation Yes No

Fax # to send notes \_\_\_\_\_

**Coverage for PREVENTATIVE MNT services includes:**

Comments:

Number of visits \_\_\_\_\_

Limit on number of units \_\_\_\_\_

Deductible applies \$ \_\_\_\_\_

Co-pay applies \$ \_\_\_\_\_

Co-insurance applies \_\_\_\_\_ %

**Coverage for MEDICAL MNT services includes:**

Comments:

ICD 10 codes to verify \_\_\_\_\_

Number of visits \_\_\_\_\_

Limit on number of units \_\_\_\_\_

Deductible applies \$ \_\_\_\_\_

Co-pay applies \$ \_\_\_\_\_

Co-insurance applies \_\_\_\_\_ %

Reference # for this call \_\_\_\_\_