Real Healthy Habits

Health & Nutrition Coaching with Registered Dietitians

TEL: 256-530-6040 **FAX: 256-937-3313**

4801 University Square, Suite 19, Huntsville, Al 35816

www.realhealthyhabits.com hello@realhealthyhabits.com

MEDICARE PATIENT REFERRAL FORM

Medicare provides coverage of Medical Nutrition Therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (GFR less than 15-50, not on dialysis).

PATIENT INFORMATION	PATIENT INSURANCE
PATIENT NAME:	**INSURANCE COMPANY:**
DATE OF BIRTH:	**ID NUMBER:**
ADDRESS:	**SUBSCRIBER'S NAME:**
	SUBSCRIBER'S DATE OF BIRTH:
PHONE NUMBER:	**SUBSCRIBER'S RELATIONSHIP TO PATIENT:**

Medicare requires a physician's referral–not a nurse practitioner or physician's assistant.

REFERRING PHYSICIAN INFORMATION	
REFERRING PHYSICIAN:	**NPI:**
TEL:	**FAX:**
SIGNATURE:	**DATE:**

MEDICAL DIAGNOSIS (CHECK ALL THAT APPLY)

	E10.__	Type 1 Diabetes Mellitus		N18.___	Chronic Kidney Disease, stage 3
	E11.__	Type 2 Diabetes Mellitus		N18.___	Chronic Kidney Disease, stage 4
	______	Other		N18.___	Chronic Kidney Disease, stage 5

LAB INFORMATION (IF AVAILABLE)

A1C:______________ **GLUCOSE:**_____________	**GFR:**____________

Please FAX us a copy of the patient's last office visit notes with labs.

The information requested above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of patient services. Please understand that as a link in the "Chain of Trust," all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.