PREMIER DIABETES CARE
16404 Smokey Point Blvd, Ste 102, Arlington, WA 98223
Phone: (425) 318-7144 Fax: (425) 748-7378
www.premierdiabetescare.com

Medical Nutrition Therapy Services Referral

Patient: Last Name First Name Middle Initial

Date of Birth _____ Gender: ☐ Female ☐ Male Other_____

Address City State Zip Code

Home Phone Cell Phone Email address

Insurance Plan **Policy/ID** **Group #** **Subscriber Name & DOB**

Secondary Insurance Plan **Policy/ID** **Group #** **Subscriber Name & DOB**

Diagnosis

Please send recent labs to support diagnostic criteria for patient eligibility & outcomes monitoring

Type 1 Diabetes ☐ ICD10 Code _____

Type 2 Diabetes ☐ ICD10 Code _____

Type 1.5 (LADA) ☐ ICD 10 Code _____

Hyperlipidemia ☐ ICD10 Code _____

Obesity ☐ ICD10 Code _____

Other Diagnosis: _____

Other Diabetes _____ **ICD10 Code** _____ **Other ICD10 Code** _____

Medical Nutrition Therapy (MNT)

MNT: 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis with a written referral from the treating physician. MNT referral to be signed by an MD or DO for Medicare patients.

☐ Initial MNT 3 hours

☐ Annual follow-up MNT 2 hours

☐ Additional MNT hours: _____ (# of hours)

☐ Other (specify): _____

Signature certifies qualification of provider who manages the patient's health condition(s) stated above:

Referring Provider Name & Title:_____ NPI #: _____

Address: _____

Phone: _____ Fax: _____

Provider Signature: _____ Date: _____

Please fax completed form, lab results, and insurance info to 425-748-7378