Alison RD
registered dietitian nutritionists

3 Allied Drive Suite 303 Dedham, MA 02026
Ph: 617-645-4819 Fax: 781-207-7981

MEDICAL NUTRITION THERAPY (MNT) ORDER FORM:

This information is required by Medicare and should be provided to the RD prior to the appointment

Patient's Name: _____ Gender: M | F | Other _____

Date of Birth: _____ Patient's Phone Number: _____

Diagnosis & ICD-10 code(s): _____

Reason for referral: (Please note that Medicare will only cover a visit if the patient has diabetes or non-dialysis kidney disease.)

_____

_____

_____

Please check the type of MNT requested (check all that apply):

- ☐ Initial MNT (3 hours in the first calendar year)
- ☐ Annual follow-up MNT (2 hours annually)

Referring Provider Signature: _____ Date: _____

NPI Number: _____ Phone Number: _____

Definition of Diabetes (Medicare):

Medicare coverage of MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- A fasting blood sugar greater than or equal to 126mg/dL on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200mg/dL on two separate occasions; or
- A random glucose test over 200mg/dL plus symptoms of diabetes.

Please fill out this form and FAX back along with labs to: 781-207-7981