



Date: _____ Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

Diabetic: YES () NO () *if Diabetic or Renal and Medicare, please also complete Medicare referral form

Referring Physician: _____ Physician Signature: _____ Phone: _____

NPI: _____ Fax: _____

INSURANCE COMPANY _____ PHONE NUMBER _____

SUBSCRIBER NAME _____ SUBSCRIBER'S DATE OF BIRTH _____

ID NUMBER _____ SUBSCRIBER'S RELATIONSHIP TO PT _____

In-network for: BCBS, Cigna, United Healthcare, Aetna, Humana, Medicare, OPTUM, MultiPlan and more.

MEDICAL DIAGNOSIS (Check all that apply)

<input type="checkbox"/>	E10.____	Type 1 diabetes mellitus	<input type="checkbox"/>	N18.____	Chronic kidney disease, stage ____
<input type="checkbox"/>	E11.____	Type 2 diabetes mellitus	<input type="checkbox"/>	I10	Essential (primary) hypertension
<input type="checkbox"/>	E78.0	Pure hypercholesterolemia	<input type="checkbox"/>	I11.____	Hypertensive heart disease _____
<input type="checkbox"/>	E78.1	Pure hyperglyceridemia	<input type="checkbox"/>	I12	Hypertensive chronic kidney disease
<input type="checkbox"/>	E78.2	Mixed hyperlipidemia	<input type="checkbox"/>	I25	Chronic ischemic heart disease
<input type="checkbox"/>	E78.3	Hyperchylomicronemia	<input type="checkbox"/>	I50	Heart Failure
<input type="checkbox"/>	E78.4	Other hyperlipidemia	<input type="checkbox"/>	K21.0	Gastroesophageal reflux with esophagitis
<input type="checkbox"/>	E78.5	Hyperlipidemia, unspecified	<input type="checkbox"/>	K21.9	Gastroesophageal reflux without esophagitis
<input type="checkbox"/>	E66.0	Obesity due to excess calories	<input type="checkbox"/>	K50.____	Crohn's disease _____
<input type="checkbox"/>	E66.01	Morbid obesity due to excess calories	<input type="checkbox"/>	K57.____	Diverticulosis of _____
<input type="checkbox"/>	E66.3	Overweight	<input type="checkbox"/>	K58	Irritable bowel syndrome (IBS)
<input type="checkbox"/>	E66.8	Other Obesity	<input type="checkbox"/>	K90.0	Celiac disease
<input type="checkbox"/>	E66.9	Obesity, unspecified.- obesity NOS	<input type="checkbox"/>	K52.2	Allergic and dietetic gastroenteritis and colitis
<input type="checkbox"/>		Other	<input type="checkbox"/>		Other

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand 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.

In-office and Virtual Nutrition services available to serve patients.

Most Major Health Insurance plans accepted including Medicare.

YourFide Dietitian-Nutritionist

Call: 770-881-8651(administration)

Send a Text: 404-590-3834

FAX: (470) 239-1564

E-mail: info@yourfide.com

EMAIL
info@yourFide.com

Phone Call us
770-881-8651

Text Us:
T404-590-3834

Fax To Us
(470) 239-1564



MEDICAL NUTRITION THERAPY REFERRAL FORM FOR MEDICARE PATIENTS

Please note, that medicare ONLY covers medical nutrition therapy (MNT) for diabetes and chronic kidney disease.
Medicare ONLY accepts referrals from physicians for MNT – Referrals from a PA or ARNP will be rejected by Medicare.

Date:	Patient Name:
Patient DOB:	Address:
Phone:	Insurance:

Please place a check "✓" next to all applicable diagnoses for the patient listed above

<input type="checkbox"/>	E10.____	Type 1 diabetes mellitus	<input type="checkbox"/>	N18.1	Chronic kidney disease, stage 1
<input type="checkbox"/>	E11.____	Type 2 diabetes mellitus	<input type="checkbox"/>	N18.2	Chronic kidney disease, stage 2
<input type="checkbox"/>	O24.410	Gestational diabetes mellitus, diet-controlled	<input type="checkbox"/>	N18.3	Chronic kidney disease, stage 3
<input type="checkbox"/>	O24.414	Gestational diabetes mellitus, insulin-controlled	<input type="checkbox"/>	N18.4	Chronic kidney disease, stage 4
<input type="checkbox"/>		Other	<input type="checkbox"/>	N18.5	Chronic kidney disease, stage 5
			<input type="checkbox"/>	Z94.0	Kidney Transplant Status

Date		Physician Name	
Office Phone		Physician Signature	
Office Fax		Physician NPI #	

Please fax this completed form and any medical records/labs to (470) 239-1564

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