MUNSON HEALTHCARE

Form 2069 (06/21)

2069

OUTPATIENT NUTRITION COUNSELING REFERRAL

Phone: 231-935-7117 | Fax: 231-935-5796

*(Do not use this form if patient has Diabetes)

Patient Legal Name:_____
First Last Middle Initial

Phone Number:_____ **Patient ID Number:**_____

DOB: _____ **Appointment: Date** _____ **Time** _____

☑ **Dietary Counseling and Surveillance** **Code:** **V65.3 / Z71.3**

PLEASE LIST EACH DIAGNOSIS AND CORRESPONDING ICD BILLING CODE BELOW:

Diagnosis: _____ **Code**:_____

Diagnosis: _____ **Code**:_____

Diagnosis: _____ **Code**:_____

Diagnosis: _____ **Code**:_____

Diagnosis: _____ **Code**:_____

Ht _____ **Wt** _____ **BMI** _____ **Code:**_____

PERTINENT LAB DATA (If not on Powerchart): **Chol** _____ **HDL** _____

For Children: Send growth chart **Trig** _____ **LDL** _____

FBS _____ **A1C** _____ **Other** _____

Diet comments/reason for referral: _____

Physician Name: (Printed) _____

Physician Signature: _____ **Date:** _____ **Time:**_____

Physician Office Phone Number: _____ **Physician Fax Number:** _____

PLEASE CHECK WITH INSURANCE PROVIDER TO SEE IF PROCEDURE CODE 97802 (Medical Nutrition Therapy) IS COVERED FOR THE DIAGNOSES LISTED ABOVE.

FAX THIS ALONG WITH MOST CURRENT OFFICE NOTES TO: 231-935-5796

PATIENT PLEASE BRING THIS FORM TO YOUR APPOINTMENT

PATIENT ID LABEL HERE