Northern Arizona Healthcare

MNT Services Order Form

Phone: 928-773-2084; Fax: 928-214-3766

Patient Name:	Telephone Number: Home: _____ Work: _____
Address:	DOB:
Insurance:	Pre-Auth #:

Diagnosis:

☐E11.9 ☐E11.65	Type 2 controlled Type 2, uncontrolled	☐ E10.9 ☐ E10.65	Type 1 without complications, controlled Type 1 with hyperglycemia, uncontrolled
☐E88.81	Metabolic Syndrome	☐ O24.419	Gestational Diabetes
☐R73.01	Impaired Fasting Glucose	☐ K90.0	Celiac/Gluten Enteropathy
☐R73.09	Prediabetes	☐ E28.2	PCOS
☐I10	Hypertension	☐ E78.2	Mixed Hyperlipidemia
☐E66.9	Obesity	☐ E66.01	Morbid Obesity
☐R63.5	Weight Gain, abnormal	☐ R63.4	Weight Loss, abnormal
☐F50.9	Eating Disorder, unspecified	☐ K31.84	Gastroparesis
☐N18._	Chronic Kidney Disease Stage __	☐K 58	Irritable Bowel Syndrome
☐E46	Unspecified protein-calorie malnutrition	☐	Other

Medical nutrition therapy (MNT) is individual and an adjunct service to improve health care.

Medical Nutrition Therapy (MNT):

Check the type of MNT and/or number of additional hours requested: ☐ Initial MNT ☐ Annual follow-up MNT ☐ Additional MNT services in the same calendar year, per RD recommendations.	*Please specify change in medical condition treatment and/or diagnosis:*
Special education needs: *Check all that apply:* ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment ☐ Language Limitations ☐ Other _____	**Current Medications:** *(please list or attach a copy of medication list).* _____ _____ _____

I certify that I am managing the beneficiary's medical condition and the training described above in the plan of care is needed to ensure therapy compliance or to provide the beneficiary with the skills and knowledge to help manage the beneficiary's health

Physician's name printed _____Office phone number:_____

Physician's Signature_____ Date: _____

Reviewed 1/10/2017