Provider NPI: 1639757271

Group NPI: 1861192965

EIN: 92-0374210

Verification of Benefits Form

Obtain copy of front & back of insurance card card & copy of patient's driver license

Patient's Name:_____

Patient's Date of birth: _____

Home Address : Street_____ **City** _____ **State**_____ **Zip**_____

Name of Insurance: _____ **Insurance ID Number:** _____

Applicable ICD 10 codes:

_____

Date: _____ Time: _____ Representative:_____

Policy type: PPO ☐ HMO ☐ POS ☐ Other _____

Benefit period: From _____ To _____

Is this a **FULLY** funded plan? Yes ☐ No ☐ Is this a **SELF**-funded plan? Yes ☐ No ☐

Is this policy a **grandfathered** plan not needing to adhere the **ACA**? Yes ☐ No ☐

Does this policy have Nutrition Counseling/Medical Nutrition Therapy Benefits? Yes ☐ No ☐

Which **CPT codes** are covered on this policy? 97802 ☐ 97803 ☐ 97804 ☐ S9470 ☐ 99401-99404 ☐

Are **BOTH** preventative nutrition services covered under **Health Care Reform** AND medical benefits covered? Yes ☐ No ☐

Does this plan cover **telehealth** services? Yes ☐ No ☐
Is there a **co-pay** for telehealth services Yes ☐ No ☐ Amount $_____

Does this plan require an **MD referral** Yes ☐ No ☐

Does this plan require **prior authorization** for nutrition services Yes ☐ No ☐ Comments

Does this plan require the dietitian submit **medical documentation** Yes ☐ No ☐
Fax # to send notes _____

Coverage for PREVENTATIVE MNT services includes: Comments:
Number of visits _____
Limit on number of units ____
Deductible applies $_____
Co-pay applies $_____
Co-insurance applies _____ %

Coverage for MEDICAL MNT services includes: Comments:
ICD 10 codes to verify _____
Number of visits _____
Limit on number of units _____
Deductible applies $_____
Co-pay applies $_____
Co-insurance applies _____ %

Reference # for this call _____