NASHVILLE

Nutrition Partners

MEDICAL NUTRITION THERAPY (MNT) REFERRAL FORM

Fax the following information to: 615-334-0867

- ☐ **Completed MNT referral form**
- ☐ **Patient Demographics with contact info**
- ☐ **Copy of patient's insurance card (if available)**

DIAGNOSIS FOR MEDICAL NUTRITION THERAPY (ICD-10 code is required for referral)

- ❑ E10.____Type 1 DM
- ❑ E11.____Type 2 DM
- ❑ E28.2 PCOS
- ❑ E66.____ Overweight/Obesity
- ❑ E78.2 Mixed hyperlipidemia
- ❑ F50.____ Anorexia nervosa
- ❑ F50.2 Bulimia nervosa
- ❑ F50.9 Eating disorder, unspecified
- ❑ I10 HTN, essential
- ❑ I11.0 HTN heart disease with CHF
- ❑ K21.____ GERD
- ❑ K50.____ Crohn's disease
- ❑ K51 Ulcerative colitis
- ❑ K52.2 Food Allergies
- ❑ K58 Irritable bowel syndrome
- ❑ K90.0 Celiac disease
- ❑ R62.51 Failure to thrive, child
- ❑ R63.4 Abnormal weight loss
- ❑ R63.5 Abnormal weight gain
- ❑ R63.6 Underweight
- ☑ R73.03 Pre-diabetes
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____

REASON FOR REFERRAL (required)

Provider Comments:

Exercise Restrictions? _____ YES _____ NO Specify:

Referring Provider Name (print)

_____

Provider Signature:

_____

Provider NPI: _____

Date of referral: _____/_____/_____

Provider Phone: _____--_____--_____

Provider Fax: _____--_____--_____

In-network payors Medicare, of Tennessee, aetna, Cigna

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