

# Medical Nutrition Therapy Medical Referral

The following information is required for reimbursement by most payers for Medical Nutrition Therapy. When completed, please fax to 800-957-1067. Thank you.

### Patient information

Name:	
Date of Birth:	
Medicare Part B /Health Ins. #:	
Phone:	

### Order:

Provide Medical Nutrition Therapy by a Registered Dietitian (97802, 97803, 97804)

### Diagnosis (Indicate ✓ the primary diagnosis):

	ICD-9	ENDOCRINE, NUTRITIONAL AND METABOLIC, IMMUNITY		ICD-9	CIRCULATORY SYSTEM
	250.00	Diabetes II/unspecified		401.9	Hypertension, unspecified
	250.01	Diabetes I		403.9	Hypertensive renal disease, unspecified
	250.02	Diabetes II/unspecified, uncontrolled		414.0	Coronary atherosclerosis
	250.03	Diabetes I, uncontrolled		428.0	Congestive heart failure, unspecified
	250.1	Diabetes with ketoacidosis			<b>DIGESTIVE SYSTEM</b>
	251.2	Hypoglycemia, unspecified		555.9	Crohn's disease NOS
	256.4	Polycystic ovarian syndrome		562.10	Diverticulosis of colon
	272.0	Pure hypercholesterolemia		562.11	Diverticulitis of colon
	272.4	Combined hyperlipidemia		564.1	Irritable bowel syndrome
	272.2	Mixed hyperlipidemia		575.9	Unspecified disorder of gallbladder
	272.9	Unspecified disorder of lipid metabolism			<b>GENITOURINARY SYSTEM</b>
	277.7	Dysmetabolic syndrome X		585	Chronic renal failure
	278.00	Obesity, unspecified			<b>OTHER</b>
	278.01	Morbid obesity			

- Physical Activity restrictions? If yes, limit to: \_\_\_\_\_
- Please attach supporting lab data. (i.e., fasting glucose, LDL, e-GFR)

### Physician information:

Name:	
NPI:	
Phone:	
Fax:	

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

Provided by **Medical Nutrition Therapy Northwest**  
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