Provider NPI:

Group NPI:

EIN:

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:

Number of visits __________

Limit on number of units ____

Deductible applies $_________

Co-pay applies $___________

Co-insurance applies ______ %

Comments:

Coverage for MEDICAL MNT services includes:

ICD 10 codes to verify _______________________

Number of visits __________

Limit on number of units ______

Deductible applies $_________

Co-pay applies $___________

Co-insurance applies ______ %

Comments:

Reference # for this call _____________________________________