



Referral for Medical Nutrition Therapy
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Name:	DOB:
Address:	Phone:

Above is referred for medical nutrition therapy as a necessary part of medical treatment and prevention of complications for diagnoses listed

Referral Needs: New Diagnosis New Treatment Plan New Complication

Check/provide all diagnoses ICD-10 codes that apply to this referral. Please utilize the "other" space to specify other ICD-10 codes as needed.

- Diabetes ICD-10 _____
- CKD ICD-10 _____
- Overweight / Obesity ICD-10 _____
- Cardiac Nutrition Z71.3 plus ICD-10 _____
- Eating Disorder ICD-10 _____
- Other ICD-10 _____

Please include the following attachments:

- Most recent lab work Medications list Latest 2 patient chart notes to confirm medical dx
- Insurance card copy front & back OR please provide the following primary insurance information:

Insurance Company Name:	Policy Holder Name (Last, First):
Policy Holder Phone Number:	<input type="checkbox"/> HMO <input type="checkbox"/> PPO
Group#	Member ID

Referring Physician's Signature: _____ MD/DO Date: _____

Printed Name: _____ NPI: _____

Phone: _____ Fax: _____

Fax referral form and attachments to (855) 670-0422

Thank you for your referral! I will contact your patient within 3 business days.

The information requested above is Protected Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.