

**Raleigh Medical Group**  
**Nutrition Therapy Referral Order Form**

Office Telephone # 919-341-3612

Fax # 919-785-2794

*Instructions: This form must be completed by your **Medical Provider**. Please include a copy of the patient's insurance card, front and back. Please fax the completed form and insurance card(s) to the number listed above or email to karen.mcdonald@raleighmedicalgroup.com.*

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender M / F

Patient Home Phone # \_\_\_\_\_ Patient Work Phone # \_\_\_\_\_

Health Plan \_\_\_\_\_ Member ID \_\_\_\_\_ Group # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Referring diagnosis/condition(s) \_\_\_\_\_

ICD-10 Code(s) \_\_\_\_\_

Medicare coverage: 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

*Check the type of Medical Nutrition Therapy (MNT) and/or number of additional hours requested*

Initial MNT                       3 hours or \_\_\_\_\_ # hours requested

Annual follow-up MNT     2 hours or \_\_\_\_\_ # hours requested

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Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name Printed: \_\_\_\_\_

NPI # \_\_\_\_\_

Group/Practice Name \_\_\_\_\_

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Practice Address \_\_\_\_\_

Practice Phone # \_\_\_\_\_ Practice Fax # \_\_\_\_\_

## Service Locations and Schedule:

- **Raleigh Medical Group** – 3521 Haworth Drive Raleigh, NC 27609  
Office Telephone # 919-782-1806 Monday & Wednesday Appointments Available
- **Raleigh Adult Medicine** – 3200 Blue Ridge Rd Suite 210, Raleigh, NC 27612  
Office Telephone # 919-781-9979 Monday & Thursday Appointments Available
- **Cary Medical Group** – 530 New Waverly Place Suite 200, Cary, NC 27518  
Office Telephone # 919-859-5955 Tuesday and Friday Appointments Available

