Home Delivered Meal Service Referral Form
for Managed Care Organizations

Today's Date: Authorization Number: _____

Authorization Start Date: Expiration Date:

ICD-10 Code: _____ Member ID Number: _____

Individual Making Meal Referral:

Organization Name: _____Referring Agency Name: _____

Case Manager/Care Coordinator Name: _____

Case Manager/Care Coordinator Email: _____ Phone: _____

Referring Provider: _____ Provider NPI#: _____

Member Receiving Meals:

Name: _____ Street Address: _____

Apartment/Suite: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Date of Birth: _____

Sex: ☐Male ☐ Female

Secondary Contact (if recipient unreachable) Relationship to Meal Recipient:_____

Name: _____ Phone: _____ Email: _____

Meal Plan Selection: Number of Meals Approved Per Week: 14 meals weekly

Nutrition Counseling: Meal Recipient is interested in nutrition counseling services: ☐Yes ☐No

DESIRED MENU TYPE (Make <u>one</u> selection*)	
☐General Wellness (carbs <65g/entrée, <650 mg sodium)	☐Heart Healthy (Sodium <500mg, Saturated fat <10%)
☐Diabetes-Friendly (carbs 45g/entrée or less)	☐Vegan (No animal products)
☐Low Inflammation (Ideal for conditions such as cancer, autoimmune disorders, arthritis, COPD, HIV, MS)	☐Gluten-free (No gluten-containing ingredients. Note our facility is not 100% gluten-free)
☐Advanced Aging (>20g protein per entrée, includes DRI snacks. Ideal for >65 years old with cachexia, muscle wasting, and malnutrition	
Preferred Proteins (select all that apply): ☐Beef ☐Chicken ☐Fish ☐Pork ☐Shellfish ☐Turkey ☐Vegan ☐Vegetarian	
Food Allergies to Avoid: ☐Dairy ☐Egg ☐Fish ☐Peanuts ☐Sesame ☐Shellfish ☐Soy ☐Tree Nuts ☐Wheat	
Special Delivery Instructions/Food Preferences/Comments/Other food allergies:	

Email Referral Form to Enroll@Nutri4longevity.com or E-FAX: (833) 231-6731. For Questions, you can call our Client Engagement Team at 973-970-9063. Hours of Operation: 8AM-5PM EST