Neighborhood Nutrition

Decide to be healthy

REFERRAL REQUEST

Today's Date: ____________________

To: ______________________________ From: ______________________________

Fax: ______________________________ Please SCAN form and email to: info@neighborhoodnutrition.com

Phone: ______________________________ **Phone:** **(602) 412 - 3587**

In order to process health insurance claims for the patient listed below, a referral is required from the Primary Care Physician for *MEDICAL NUTRITION THERAPY.*

PATIENT NAME:	**First:** **Last:** ☐ **M** ☐ **F**	
DATE OF BIRTH:	/ /	**Referral Reason Code (ICD-9):**
INSURANCE PLAN NAME:	☐ **AZ Blue Cross Blue Shield** ☐ **Aetna** ☐ **CIGNA** ☐ **(Other):**	
IDENITFICATION NUMBER:	**Prefix:** **ID Number:**	
PRIMARY CARE PHYSICIAN:	**Name:** **Phone:**	
DATE OF APPOINTMENT:	/ /	**Number of Visits:**
REGISTERED DIETITIAN NAME:	☐ **Barbara Ruhs, MS, RD, LDN – NPI # 136 649 1607** ☐ **Natalie Verderame, RD**	

Group NPI: **1427220946**

Group Name: **Barbara Ruhs, Neighborhood Nutrition LLC**