

Insurance Coverage Verification

It is the patient's responsibility to verify insurance coverage for their specific plan for Medical Nutrition Therapy or Nutrition Counseling benefits. Any resulting balance is the patient's responsibility to pay in full.

Practitioner Name: Shelby Slenkamp

NPI: 1790331056

Name: _____ Date ____/____/____

Patient Address: _____ City, Zip _____

Patient Phone Number: (____) _____ - _____ Email _____

Insurance Information

Insurance Company _____

Member ID _____ Group Number _____

Medical Nutrition Therapy Benefits for CPT codes 97802 & 97803 **Y** **N**

Is a physician referral necessary for these benefits to be covered? **Y** **N**

Are there benefit limits based on diagnosis? **Y, limited to** _____ **N**

Is there a visit or unit limit? **Y, Limit is** _____ **N**

Does my deductible need to be met before these benefits are covered? **Y, remaining** _____ **N**

Is there a copay or coinsurance for these benefits? **Y, copay is** _____, **coinsurance** _____ **N**

Does my insurance plan cover telehealth for CPT 97802 and 97803? Y N

I understand that it is my responsibility to check my specific insurance plan benefits and that any resulting fee will be my responsibility to pay in full and the credit card/debit card/FSA/HSA below will be charged:

Card number _____ - _____ - _____ - _____ Exp date _____

Security code: _____

SIGNATURE x _____ Date ____/____/____.