KOKUA Lifestyle and Nutrition

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: (___) _____ - _____

Insurance Information

Insurance Company _____

Insurance Plan Name _____ Group Number _____

Member ID (PRE 0000000 01) _____

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** **N**

If yes, those limits are _____

Is there a visit or unit limit? **Y** **N**

If yes, those limits are _____

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

If yes, my current deductible is _$_____ and I have met _$_____

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

If yes, the *copay* is $_____ OR the *coinsurance* is _____%

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.

SIGNATURE _____ Date ___/___/___.

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