Medical Nutrition Therapy (MNT)

Verification of Benefits Form

Please fill this form out in its entirety. This form will help you ask the appropriate questions to better understand your benefits regarding MNT. Ultimately the patient is financially responsible for payment of non-covered services. Once complete, please fax or email us the completed form at 410.975.5641 or register@inspire-im.com respectively. Incomplete forms will not be accepted. Please note: You will be expected to sign an Advanced Beneficiary Notice accepting financial responsibility for non-covered services prior to each visit.

Patient Name: _____ Date of Birth:_____

Insurance Plan (circle primary): Aetna BC/BS CIGNA

Tricare United Other: _____

To verify benefits:

1) Call the toll-free member services number on your insurance card.

2) Ask to speak to a representative to verify benefits.

   a. Members should record the date of their call, the representative name, and a call reference number.

      Reference number: _____

      Date of Call: _____

      Representative name: _____

3) Ask the representative for the following information:

   a. Does my insurance cover the following two (2) CPT codes?

      i. 97802 – Initial MNT Visit Yes or No

      ii. 97803 – Subsequent MNT Visits Yes or No

   b. Does my insurance cover any of the following diagnosis codes?

      _____

      _____

If so, please complete the following information: (circle one for each question)

How many visits are allowed per calendar year? Ask for specific minimum number of visits allowed: _____

Do I need a referral from my PCP? Yes No

Will MNT be covered via virtual visits? Yes No

Patient Signature: _____

Form Date: _____