**Call the Member Services Number on the Back of your Insurance Card:**

Company Name: Nutrition in Motion, LLC

* Tax ID: 26-2588647
* Group National Provider Identifier (NPI): 1548437312
Provider NPI \_1235531120\_\_\_\_\_\_

**Questions to ask your Insurance Service Representative**

1. Does my plan cover preventative medical nutrition therapy under the Affordable Care Act (ACA) or Health Care Reform? □ Yes □ No
	1. Are there any exclusions? □ Yes □ No
	If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Procedure codes for nutrition appointments:*

97802 - Procedure code for an **initial** nutrition counseling appointment
97803 - Procedure code for a **follow-up** nutrition counseling appointment

1. Is my plan self-funded by my employer or a commercial plan? □ Self Funded □ Commercial
2. Will my plan cover medical nutrition therapy for (your health conditions)?

List the health conditions that you want to address at a your appointment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No

*Sample Diagnosis Codes:* Z71.3 – Dietary Counseling , Z72.4 – Inappropriate diet and eating habits, E66.3 Overweight, E66.9 – Obesity Unspecified, E10.9 – Type 1 Diabetes, E11.9 – Type 2 Diabetes

1. Do I have a deductible to meet first\*? □ Yes □ No
If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do I have a copay or coinsurance\*? □ Yes □ No
If yes, how much? \_\_\_\_\_\_\_\_\_\_\_
3. Do I need a physician referral? □ Yes □ No
4. Do I have a limited number of visits? □ Yes □ No
If yes, how many visits can I have per benefit period? \_\_\_\_\_\_\_\_\_\_\_\_
What is my benefit period? Start date: \_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_

\*If you are told there is a member cost share (deductible, copay, or coinsurance) but also have preventative coverage (see question 1), ask member services to specify what services are covered under preventative care. You should not be responsible for member cost share for preventative services under the ACA.

**We suggest you record the date, time and name of the representative and keep a copy of this**

**information for your records.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_ Name of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reference # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_