In Office Use:
Labs: _____
Referral: _____
Insurance Card: _____

Path of Life Healing Center

Stimulating Cellular Beauty

NUTRITION MEDICAL BENEFITS INTAKE SCREENING

Patient's full Name: _____

Date of Benefits Inquiry: _____ | Provider Insurance Network: _____
Customer Service Representative's Name: _____; Department: _____
Telephone: _____; Call Reference Number: _____
First Appointment: Date: _____; Time: _____ (Make your appointment online at https://www.pathoflifehealing.com)

PATH OF LIFE HEALING CENTER is committed to providing you the best care. To achieve our goals, we need your assistance: **Print and Bring Completed Form with You or Email Ahead of Time!** Please **contact the customer service / benefits department of your insurance company** to determine your coverage for **nutritional counseling.** Provide the required information and write the responses in the corresponding spaces:

Member ID #: _____, Group #: _____, the number is located on the front of your card. If you have letters, please let them know. **Your birthdate:** _____; **Provider Network Account Number**: _____, Plan Name: _____; Plan Option: _____; **For Dependents:** if you are a dependent, give the subscriber's name and date of birth: Subscriber's Name: _____, Date of Birth: _____, Relationship: _____

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PLEASE ASK THE INSURANCE CUSTOMER SERVICE REPRESENTATIVE THE FOLLOWING QUESTIONS:

- Do I have benefits for **Medical Nutrition Therapy - CPT codes 97802 or 97803 or S9470**? **YES / NO** _____
  - If yes, does the benefit have restricted diagnosis coverage? i.e., diabetes only or does not cover Obesity? _____, Is non-preventive care covered: Yes / No… Any additional services covered: _____. What conditions/services are excluded from this coverage? _____
- According to my benefits, do I need **PRIOR AUTHORIZATION** for nutrition services? **YES / NO.** If yes, what is my **prior authorization number**: _____.
- Do I have a **nutrition CO-PAY for each visit**? Yes | No… If yes, how much is each visit? $ _____
- Do I have a nutrition **deductible**? If yes. how much? $ _____; has it been met? Yes / No _____
- If no, how much deductible is remaining? $ _____ Do I have to meet the deductible before my nutrition visits are paid by this Insurance? _____

Note: This is particularly important info… Some plans have a life-time maximum.

- Do I have a limited **number of nutrition visits per calendar year**? If yes, how many? _____ . If limited per calendar year, can I start nutrition visits again the next year? _____ If necessary, ask when: _____.

Note: Medical Information

- Does nutritional counseling coverage **require a referral from my primary care provider**? YES / NO _____
- Patient Physician: _____; NPI: _____; Tele: _____
- Do I have **out-of-network benefits if I choose a nutritionist** outside the network? YES / NO _____
  - If yes, at what percentage are my visits covered? % _____
- Bring with you: A) physician's referral-if necessary, (B) Insurance Card, (C) Most recent Lab values