

Medically Tailored Meals/Medical Nutritional Therapy Referral

Service Description: Medically Tailored Meal (MTM) services support members with nutrition-sensitive chronic or serious health conditions. Based on individual nutritional needs, members may receive medically tailored meals, groceries or other specialized food services. MTM services are available for up to 12 weeks, and any extension requests must include clinical justification for CalOptima Health to determine medical necessity.

Member Information

Member Name: _____

Member CIN: _____

Member DOB: _____

Member's Phone #: _____

Referral Reason (Select all that apply)

1. Select one or more of the following health conditions that apply AND describe the nutrition therapy recommendation by the primary care provider (PCP) or treating physician.

- ☐ Cancer. *Type of cancer or treatment:* _____
- ☐ Congestive heart failure. NYHA III ☐ or ☐ NYHA IV
- ☐ Cardiovascular (CV) disorders. *Describe CV disorder:* _____
- ☐ High cholesterol/dyslipidemia. Provide most recent lab results: _____
- ☐ Chronic kidney disease. ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ ESRD on dialysis
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Cystic fibrosis
- ☐ Diabetes. ☐ The patient's HgbA1C >8 within the last three months
- ☐ Gestational diabetes
- ☐ High-risk perinatal condition. Explain: _____
- ☐ Congenital errors of metabolism. *Describe types:* _____
- ☐ Elevated lead levels with anemia. Chelation therapy: ☐ Yes ☐ No
- ☐ Severe intestinal/digestive disorder. *Describe types of clinically significant GI disorder:* _____
- ☐ HIV with significant weight loss. ☐ >5% unintentional weight loss within three to six months
- ☐ Obesity ☐ BMI >35% ☐ BMI >30 % with other comorbidities. *Describe comorbidities:* _____
- ☐ Epilepsy. ☐ The patient has refractory epilepsy. ☐ The patient is cleared of any health conditions that might be worsened by following a high fat/protein diet. *Document frequency of seizures:* _____
- ☐ Severe mental health. This patient has a serious mental illness (SMI) diagnosis and is a client of county behavioral health ☐ Yes ☐ No
- ☐ Other nutrition sensitive conditions. *Explain:* _____

☐ Patient is discharged from the hospital or nursing facility with diet/nutrition as part of the discharge plan

2. Select all the nutrition-related symptoms that the patient is currently experiencing:

- ☐ Malnutrition/failure to thrive, unintended weight loss
- ☐ Excess weight gain
- ☐ Poor appetite/early satiety
- ☐ GI distress (nausea, vomiting, diarrhea, bloating)
- ☐ Dysphagia
- ☐ Shortness of breath
- ☐ Edema
- ☐ Electrolyte imbalance
- ☐ Hyperglycemia or hypoglycemia
- ☐ Other, please describe _____

3. Requests for MTM beyond 12 weeks require documentation showing medical necessity, the member's ongoing engagement with their PCP or specialist, adherence to scheduled appointments and treatments, and evidence of active care coordination between the MTM provider and the health care team.

Referring Health Care Team and Attestation (Attach lab reports and/or recent progress notes)

4. Referring Health Care Team

- ☐ PCP
- ☐ Specialist. Specialty: _____
- ☐ Inpatient provider
- ☐ Registered dietitian (RD)
- ☐ Hospital social worker
- ☐ Other clinicians. Role: _____

ATTESTATION: As a member of the member's established health care team, or as a representative of the managed care plan, I attest that the member has a nutrition-sensitive diagnosis. The member's health care team will continue to oversee the member's health and identify any changes while the member is receiving Medically Tailored Meals.

Print Name: _____
Specialty or Role: _____
Fax #: _____
Telephone #: _____
Signature: _____
Date: _____

Complete and Fax Form to 714-338-3145