



Out-of-Network Dietitian Nutrition Counseling Benefit Breakdown

Date: _____

Insurance company: _____

Insurance phone number: _____

Patient name: _____

Provider name: _____

Provider date of birth: _____ Provider SSN#: _____

Deductible? _____

Percentage of coverage after deductible is met? _____

Is pre-authorization required? Yes / No

Is a referral required? Yes / No

Number of visits? _____

Per calendar year or per contract year?

Services covered: (ICD10 code Z71.3, CPT codes 97802, 97803)

Any other requirements or restrictions?

Name of customer service representative: _____

Reference number* for phone call: _____