**REFERRAL FOR DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT**

**& MEDICAL NUTRITION THERAPY SERVICES**

*Fax completed form and current labs to: (904) 272-9149*

*Call (904) 276-8050 for more information*

**Date: _____**

**Referring Provider and NPI: _____**

**Participant's Name: _____ DOB: _____**

**Phone#: _____**

**Diabetes Diagnosis:**

☐Type 1 ☐ Type 2 ☐ Gestational
☐ Pre-Existing DM with Pregnancy ☐ Pre-diabetes

**Referral For:**

☐ Initial Comprehensive Diabetes Self-Management Training(DSMT) – 10 hrs. and all 9 topics
☐ DSMT: Follow-up – 2 hrs.
☐ Medical Nutrition Therapy (MNT) Initial – 3 hrs.
☐ MNT: Follow up – 2 hrs.
☐ Specific Topics and Hours if needs vary from above:_____
*DSMT can be ordered by an MD, DO or midlevel provider managing the participant's diabetes.
**MNT can be ordered by any MD or DO.

**Indicate any barriers to group learning or additional insulin training requiring _____ hours of 1:1 instruction:**

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity

☐ Impaired mental status/cognition ☐ Language barrier ☐ Eating disorder

☐ Learning disability or other (please specify):_____

☐ 1:1 Insulin Training

## *Procedure codes to use when requesting HMO or Medicaid pre-authorization*:

**DSMT** G0108 Individual per 30 minutes
G0109 Group per 30 minutes
**MNT** 97802 Individual per 15 minutes initial
97803 Individual per 15 minutes follow-up

**Physician's Signature** _____ **Date** _____