AA NUTRITION LLC

PROVIDER REFERRAL FORM

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Scan for Fillable Blank Form

1 REFERRING PROVIDER

Provider name and credentials

Practice / clinic

Office phone

Office fax

Office email

2 PATIENT INFORMATION

Patient full name

Date of birth (MM/DD/YYYY)

Patient phone

Patient email (optional)

3 REASON FOR REFERRAL (check all that apply)

- ☐ Prediabetes - R73.03
- ☐ Type 2 diabetes without complications - E11.9
- ☐ Overweight - E66.3
- ☐ Obesity, unspecified - E66.9
- ☐ Hyperlipidemia, unspecified - E78.5
- ☐ Hypertension - I10
- ☐ IBS, unspecified - K58.9
- ☐ Constipation, unspecified - K59.00
- ☐ Dietary counseling and surveillance - Z71.3
- ☐ Other (specify below)

Other diagnosis / ICD-10-CM code (if applicable)

4 SCHEDULING & ADDITIONAL DETAILS

- ☐ Patient will contact AA Nutrition to schedule
- ☐ Please contact patient to schedule

Additional notes (optional)

Submit via fax: (425) 577-6524 or another approved secure referral channel.

Do not email this completed form through unencrypted email.

In-network: Regence, Premera, Aetna, UnitedHealthcare, Cigna, Kaiser, First Choice Health, Asuris, BridgeSpan, HMA, RGA, Meritain | Self-pay available

Provider authorization: By submitting, you confirm authority to share this referral.

Codes are examples; referring clinician should confirm documented diagnoses and coding.