REQUEST FOR HOME MEAL DELIVERY
Please Complete and Fax to Windsor Outpatient Services at 615-782-7842
Phone: 1-800-316-2273

Member's Name: ________________________________ ID#: _____________________ DOB: ______________

Address: ____
City State Zip

Member's Phone #: (___) __________________________

Ordering Provider: _______________________________ Phone: (______) ____________ Fax: (_) ____________

Purpose: To address malnutrition and nutritional compromise related to medical treatment and acute illness for which adequate nutrition is an important component of the optimum treatment plan. Specialty diets are not available.

This benefit will require a physician order and prior authorization based on the following criteria. Authorization will be provided initially for a 5-week period of time. To prevent lapse in delivery, reorder request should be received by the end of the 4th week. Each reorder will require documentation of re-evaluation by the prescribing physician to assure continued medical necessity.

☐ Initial order ☐ Reorder: **Must attach clinical re-evaluation to support continued medical necessity.**

Meal Types available:

☐ 5-Day/W Regular Diet ☐5-Day/W Diet (low calorie dessert) ☐7-Day/W Diet (low calorie dessert)

Height: ____________________ Weight: ___________________

Please check applicable criteria:

- ☐ Patient hospitalized for 7 or more days discharged to home and meals ordered within 3 days of discharge to home
- ☐ Patient had major surgical procedure and meals ordered within 3 days of return home
- ☐ Patient has burns or skin breakdown or wound and BMI <20 and receiving home health services
- ☐ Patient has BMI <20 and recent documented weight loss of 10 lbs or more over the last 3 months – MUST ATTACH SUPPORTING NOTES AND LABS TO DOCUMENT MALNUTRITION STATE OR CLINICAL DX OF MALNUTRITION.

____ ____________________

Ordering Provider Signature **Date**

BENEFIT LIMIT: 100 MEALS PER YEAR

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