

Medically Tailored Meals/Medically Supportive Food are available to eligible members recently discharged from a hospital or skilled nursing facility, at high risk of hospitalization or nursing facility placement or with Chronic Condition(s).

Send the completed referral via secure fax to UM Prior Auth Fax: (800) 811-4804 *The form must be completed in its entirety to be valid. Incomplete forms will not be processed. Urgent requests must be submitted within 7 calendar days of the member's discharge from hospital.

CS Service Information	n:			
CS Service Start Date ¹ :		CS Service	End Date:	
CS Service Urgency: Continue Request Con				
CS Service:	Service Other CPT CPT Code: Code:	Γ Modifier:	Other # of Service Un Modifier:	nits:
Diagnosis:		Diagnosis C	code:	
Requested Provider (if k	mown):	-		
Special Notes/Comment	ES:			
Eligibility Criteria:				•.1
Molina Enrollment:	☐ Medi-Cal member active with Molina	Molina for M	P EAE (Duals members active v Iedicare and Medi-Cal) P Non-EAE (Duals member act Iedi-Cal)	
Member must meet on	e of the three (3) following	criteria:		
\Box Recovering from hos	() E		Discharge(d) Date:	
□ Transitioning from nursing facility to home or at high risk of hospitalization or nursing facility placement □ Discharge(d) Date:				
□ Chronic Conditions such as but not limited to Diabetes, Cardiovascular Disorders, Congestive Heart Failure, Stroke, Chronic Lung Disorders, HIV, Cancer, High Risk Perinatal Condition or Disabling Behavioral Health Disorders				
 <i>provider.</i> All pediatric requestions Gestational diabout High-risk perination Mental / Behaviot Physical & Cogn 	uests (under 18 years)	nagia)	e signed by the <i>member's trea</i>	ting

¹ Community Support Service dates cannot overlap with an existing active authorization for the same service. Overlapping requests may be returned to the requester to revise service dates.

² Urgent CS Service Level may only be applied to requests for members who have discharged from an acute care facility within the last 7 calendar days.



Community Supports Medically Tailored Meals/Medically Supportive Food Initial Request

Diabetes Cardiovascular Disorders D'ype I Gestational Diabetes Laxt Ale Value: Click or tap here to enter text. Dogestive Heart Failure Date: Click or tap to enter a date. Hyperflipidemia Chronic Kidney Disease Blood Pressure (sys/dia): Click or tap here to enter text. Date: Click or tap to enter a date. B' Date: Click or tap here to enter text. Date: Click or tap to enter a date. Total Cholesterol: Click or tap here to enter text.mg/dL Choistorio Date: Click or tap to enter a date. Triglyceride Level: Click or tap to enter a date. Other Health Condition / Diagnosis: Click or tap here to enter text. ICD-10 Code: Click or tap here to enter text. Please submit any clinical notes or other documentation in support of this referral. This includes available lab values. Required Attestations: I attest the Member or Member's Authorized Representative consented to Medically Tailored Meals or Medically Supportive Food services. I attest the Member is not receiving meal services through CalFresh or other food/nutrition programs such as Special Supplemental Benefits for the Chronically III (SSBCI) and/or WIC. I attest the Member: Fax Number: Referrer Organization Name: PoB: Medically Supplemental Benefits for the Chronically III (SSBCI) and/or WIC. Preferred Language: Delivery Address: Cill Proces:	Select from the conditions below and add any available diagnosis section below. Include corresponding ICD-10	
□ Type I □ Gestational Diabetes □ Congestive Heart Failure □ Stroke Last Alc Value: Click or tap here to enter text. □ HyperInjidemia □ Hypertsion Date: Click or tap to enter a date. □ HyperInjidemia □ Hypertsion Distage 3 □ Stage 4 □ End-Stage Renal Disease □ Total Cholesterol: Click or tap here to enter text. Date: Click or tap to enter a date. □ Triglyceride Level: Click or tap here to enter text. Dialysis Last cGFR Value: Click or tap here to enter text. □ Triglyceride Level: Click or tap here to enter text. Date: Click or tap to enter a date. □ Triglyceride Level: Click or tap here to enter text. Other Health Condition / Diagnosis: Click or tap here to enter text. ICD-10 Code: Click or tap here to enter text. Other Health Condition / Diagnosis: Click or tap here to enter text. ICD-10 Code: Click or tap here to enter text. Please submit any clinical notes or other documentation in support of this referral. This includes available lab values. Referral Artestations: □ attest the Member or Member's Authorized Representative consented to Medically Tailored Meals or Medically Supportive Food services. □ □ attest the Member is not receiving meal services through CalFresh or other food/nutritional needs. Referrer Referrer Mame: □ Title: □ R		
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	General Wellness	· · · · · · · · · · · · · · · · · · ·

MCA HCS | Community Supports



Community Supports Medically Tailored Meals/Medically Supportive Food Initial Request

Lower Sodium (sodium < 600mg)	
Heart-Friendly (sodium<800mg, total fat<30%, saturated fat<10%)	
Renal-Friendly (sodium<700mg, potassium<833mg, phosphorus<300mg)	
Diabetes-Friendly	
Gluten-Free (Tested less than 20ppm. Not a dedicated kitchen)	
Cancer Support (calories>600, protein>25g)	
Vegetarian (Includes dairy, eggs, plant, nuts and beans. Vegan not available)	
Pureed (For dysphagia members and those with difficulty swallowing)	
Shelf Stable Meals	
Order Information:	
Food Allergies:	
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Meals for Post Hospital Discharge \Box 2 Weeks	□ 4 Weeks
	□ 4 Weeks □ 12 Weeks
(within 7 days)^3 \Box 2 weeksMeals for Chronic \Box 6 Weeks \Box 8 Weeks	
(within 7 days)3 \Box 2 weeksMeals for Chronic Conditions \Box 6 Weeks \Box 8 Weeks	
(within 7 days)3 \Box 2 weeksMeals for Chronic Conditions \Box 6 Weeks \Box 8 Weeks	
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³ Requests for meals for post hospital discharge must be submitted within 7 calendar days of the member's hospital discharge. MCA HCS | Community Supports 01/2025