MOLINA HEALTHCARE

Community Supports
Medically Tailored Meals/Medically Supportive Food
Reauthorization Request

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:					
CS Service Start Date[1]:				CS Service End Date:	
CS Service Urgency: ☐ Routine Request ☐Urgent Request[2] *(request must be within 7 days of member's hospital discharge)*					
CS Service:	Service CPT Code:	Other CPT Code:	Modifier:	Other Modifier:	# of Service Units:
Diagnosis:				Diagnosis Code:	
☐ Meal request reviewed and approved by Registered Dietician					
Requested Provider (if known):					
Special Notes/Comments:					

Eligibility Criteria:		
Molina Enrollment:	☐ Medi-Cal member active with Molina	☐ CA DSNP EAE (Duals members active with Molina for Medicare and Medi-Cal) ☐ CA DSNP Non-EAE (Duals member active with Molina for Medi-Cal)
Member must meet one of the three (3) following criteria:		
☐ Recovering from hospitalization		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 ***Please list Chronic Condition(s):***		
☐ **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 Attention: The following bulleted conditions require that this form be signed by the ***member's treating provider.*** • All pediatric requests (under 18 years) • Gestational diabetes		

[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.

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- High-risk perinatal / postpartum conditions
- Mental / Behavioral health conditions
- Physical & Cognitive Disabilities (e.g. dysphagia)
- Conditions not listed in the eligibility population subset

Select from the conditions below and add any available lab values. If condition is not listed, please add in the diagnosis section below. Include corresponding ICD-10 code.

Diabetes
☐ Type I ☐ Type II ☐ Gestational Diabetes
Last A1c Value: Click or tap here to enter text.
Date: Click or tap to enter a date.

Chronic Kidney Disease
☐ Stage 3 ☐ Stage 4 ☐ End-Stage Renal Disease / Dialysis
Last eGFR Value: Click or tap here to enter text.
Date: Click or tap to enter a date.

Cardiovascular Disorders
☐ Congestive Heart Failure ☐ Stroke
☐ Hyperlipidemia ☐ Hypertension
Blood Pressure (sys/dia): Click or tap here to enter text.
BP Date: Click or tap to enter a date.

Total Cholesterol: Click or tap here to enter text.mg/dL
Cholesterol Date: Click or tap to enter a date.

Triglyceride Level: Click or tap here to enter text.mg/dL
Triglyceride Date: 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.

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 I have verified the Member or Member's Authorized Representative consented to Medically Tailored Meals or Medically Supportive Food services.

☐ I attest I have verified the Member is not receiving meal services through CalFresh or other food/nutrition programs such as Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or WIC.

☐ I attest that Medically Tailored Meals are not being utilized solely to address food insecurity and are provided as part of a comprehensive care plan to meet the Member's medical and nutritional needs.

Requestor Information:

Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:

Referrer Organization Name:

Referrer Name:	Title:
Referrer Phone Number:	Fax Number:

Member Information:

Member Name:		DOB:
Medi-Cal ID:		Preferred Language:
Delivery Address:		
City:	State:	Zip Code:

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Home Phone Number:	Cell Phone Number:
Alternate Contact Name:	Phone #:

Desired Menu:	**(Select only ONE option)**
General Wellness	☐
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:			
Meals for Chronic Conditions	☐ 6 Weeks	☐ 8 Weeks	☐ 12 Weeks
Comments/Special Delivery Instructions:			