HEALTH-E-FIT

MEDICAL FITNESS SERVICE REFERRAL FORM

Patient Info: *Click on grey areas to enter data	
Name:	DOB:
Preferred Phone:	Insurance:
Email:	Policy #:

Primary Diagnosis code(s):				
1.	2.	3.	4.	5.

Referring Provider:	
Name:	
NPI:	Practice Name:
Phone:	Fax:

Health Outcome Measures		
Check	Expected Outcome/Measure	Notes
☐	**A1c Reduction**	
☐	**Lowering Blood Pressure**	
☐	**Increased HDL/Lowered LDL**	
☐	**Weight Management (Obesity)**	
☐	**Nutrition Education/Guidance**	
☐	**Pain Management**	
☐	**Remote Patient Monitoring (select)** ○ **Glucose** ○ **Weight** ○ **Blood Pressure** ○ **Pulse Oximetry**	

Check	Frequency
☐	3X Week
☐	2X Week

Check	Duration
☐	12 Weeks
☐	8 Weeks (refill)

Important: Please submit *supportive clinical documentation* to substantiate the medical necessity for service including but not limited to: H&P, office notes, laboratory and imaging results, and skilled therapy notes.

Provider Signature: Date:

WHERE EXERCISE AND NUTRITION IS MEDICINE

FAX COMPLETED FORM TO: 833-254-1976