

Insurance Benefit Script

Please complete prior to starting services.

Please call the customer service number on the back of your insurance card and ask the following questions to determine if nutrition counseling services are covered by your plan.

It is the client's responsibility to contact their insurance company prior to starting services to verify benefits & eligibility and to inquire about potential out-of-pocket cost.

Alo Nutrition does not verify insurance benefits & eligibility. You may elect to skip this form and not check your benefits & eligibility. If services are not covered by your insurance, you will be responsible for the full cost of the session per the rates in the billing agreement.

I hereby agree to the document above.

Name of your insurance representative.

Is Alo Nutrition IN NETWORK with my plan? Or OUT OF NETWORK?

Please select all that apply

In Network

Out of Network

Does my plan cover nutrition counseling appointments with a registered dietitian?

Please select all that apply

Yes

No

Do I need a physician referral?

Please select all that apply

Yes

No

Do I need a prior authorization?

Please select all that apply

Yes

No

Do I have medical benefits for nutrition counseling and/or nutrition education? (for an eating disorder use code F50.89)

Please select all that apply

- Yes
- No

How many visits are covered and/or is there a limit on the number of visits?

Do I have preventative benefits? Is 'Z71.3 dietary counseling and surveillance' covered?

Please select all that apply

- Yes
- No

How many visits are covered and/or is there a limit on the number of visits?

Do I have benefits for diabetes counseling? Ask this question even if you do not have diabetes.

Please select all that apply

- Yes
- No

Are there any restricted diagnoses?

Please select all that apply

- Yes
- No

Restricted diagnoses

Check off all billing (CPT) codes covered:

Please select all that apply

- 97802 (initial appointment)
- 97803 (follow-up appointment)
- 99401-99404

Do I have a deductible to meet before insurance pays?

Please select all that apply

- Yes
- No

Deductible amount

Do I have a copay?

Please select all that apply

Yes

No

What is my copay? (write N/A if no copay)

Are telehealth visits covered?

Please select all that apply

Yes

No

Reference number for the call.

Any other information of note?

Date*