In Lieu of Services: Nutrition prior authorization request form

UnitedHealthcare Community Plan of Michigan is providing food services through Medically Tailored Home-Delivered Meals or Produce Prescription in select counties.

To refer a member to the program, please complete the form below and send by email to **uhcmimedicaidnutrition@uhc.com**.

- **Medically Tailored Home-Delivered Meals (MTM):** Fresh or frozen home-delivered meals that are medically tailored for a specific disease or condition
- **Produce Prescription (PP):** A voucher to purchase any variety of fruits and vegetables from a participating food retailer. A voucher transaction may be facilitated manually or electronically, depending on the most appropriate method for a given food retail setting. Items purchased must align with one of the following: Women, infants and children-eligible fruits and vegetables, Gus Schumacher Nutrition Incentive program-eligible fruits and vegetables or Double Up Food Bucks Michigan-eligible foods.

All fields are required and must be completed to process. Incomplete forms will be returned for lack of information. **If the criteria are met, the request is approved; if the criteria are not met, the request is reviewed by a medical director.

Member information		
Member name:	Member state assigned ID:	
Member address:		
City:	County:	State:
ZIP code:	Member phone number:	

Requesting provider information	
Referring provider:	Referring provider phone number:
Referring provider TIN/NPI:	

Referring party organization		
Did an organization refer member to you to obtain services? ☐ Yes ☐ No		
If yes, who?		
☐ Hospital	☐ Specialty	☐ Other
☐ Skilled nursing facility	☐ Community organization	
☐ Primary care provider	☐ County/Public agency	

United Healthcare Community Plan

Medical information

What program are you referring the member to? (Only 1 program is allowed) ☐ MTM **or** ☐ PP

Does the member consent to participating in this program? ☐ Yes ☐ No

☐ By checking this box, you are attesting that all information provided on this form has been validated. Also, where indicated on this form that you have captured member consent, you will be able to present documentation substantiating this claim with dates, times, signature, voice capture and/or phone records, which will be required upon any prospective audit.

Member has UnitedHealthcare Community Plan of Michigan as their primary insurance: ☐ Yes ☐ No

Is the member food insecure? ☐ Yes ☐ No

Does the member have a microwave/refrigerator? ☐ Yes ☐ No

Is member enrolled in SNAP and/or WIC? ☐ Yes ☐ No	SNAP or WIC?
If no, are they in the process of enrolling? ☐ Yes ☐ No	SNAP or WIC?

Has the member been determined ineligible for SNAP and/or WIC within the past 12 months?

☐ Yes ☐ No SNAP or WIC? Select

Medically Tailored Home-Delivered Meals

Members will be eligible for services if they meet at least 1 of the clinical risk factors, the 1 social risk factor and the service limitations.

Does the member have a clinical risk factor? ☐ Yes ☐ No

Has the member been in a hospital or skilled nursing facility in the last 60 days? ☐ Yes ☐ No

If yes, date of last admission:

Is the member likely to end up in the hospital or another facility if they can't access health food?

☐ Yes ☐ No

If yes, check the clinical risk factor:

☐ Nutrition-sensitive conditions	☐ Hypertension	☐ Renal disease
☐ Diabetes	☐ Human immunodeficiency virus (HIV)	☐ Gestational diabetes
☐ Congestive heart failure (CHF)	☐ Cancer with malnutrition	☐ Other high-risk perinatal conditions
☐ Chronic obstructive pulmonary disease (COPD),	☐ Sickle cell disease	

Does the member have a social risk factor? ☐ Yes ☐ No

Requested ICD-10 code(s):

Does the member have current capacity to shop and cook for themselves? ☐ Yes ☐ No

Does the member have adequate social support to meet these needs? ☐ Yes ☐ No

Is the member currently receiving duplicative support through other federal, state or locally funded programs? ☐ Yes ☐ No

Is the member eligible for a Medicaid-covered service that is substantively the same? ☐ Yes ☐ No

Does the member live in one of these counties? ☐ Yes ☐ No

If yes, check the county member resides in:

☐ Allegan	☐ Ionia	☐ Montcalm	☐ Saint Clair
☐ Barry	☐ Kent	☐ Muskegon	☐ Sanilac
☐ Eaton	☐ Lake	☐ Newaygo	☐ Shiawassee
☐ Genesee	☐ Lapeer	☐ Oceana	☐ Tuscola
☐ Huron	☐ Mason	☐ Osceola	
☐ Ingham	☐ Mecosta	☐ Ottawa	

Is the member at risk for nutritional deficiency due to food insecurity? ☐ Yes ☐ No

Produce Prescription

Members will be eligible for services if they meet at least 1 of the clinical risk factors, the 1 social risk factor and the service limitations.

Have they been in a hospital or skilled nursing facility in the last 60 days? ☐ Yes ☐ No

If yes, date of last admission:

Are likely to end up in the hospital or another facility if they cannot access healthy food? ☐ Yes ☐ No

Does the member have a clinical risk factor? ☐ Yes ☐ No

If yes, check the clinical risk factor:

☐ Cancer with malnutrition	☐ History of previous pregnancy, delivery or birth complication including: • Gestational diabetes • Preeclampsia • Preterm labor • Preterm birth • Placental abruption • Newborn low birth weight • Stillbirth • Hyperemesis gravidarum and other causes of dehydration • Maternal low birth weight of less than 2,500 grams	☐ Human immunodeficiency virus (HIV)
☐ Chronic obstructive pulmonary disease (COPD)		☐ Hypertension
☐ Congestive heart failure (CHF)		☐ Nutrition-sensitive condition
☐ Diabetes		☐ Renal disease
☐ High-risk pregnancy		☐ Sickle cell disease

Is member in foster care and at risk of developing an illness? ☐ Yes ☐ No

Is the member a child with elevated blood lead levels or childhood obesity? ☐ Yes ☐ No

Is the member a child eligible for the Children's Special Health Care Services (CSHCS) program?
☐ Yes ☐ No

Requested ICD-10 code(s):

Does the member live in one of these counties? ☐ Yes ☐ No

If Yes, check the county the member resides in:

☐ Clinton	☐ Huron	☐ Saint Clair	☐ Tuscola
☐ Eaton	☐ Ingham	☐ Sanilac	
☐ Genesee	☐ Lapeer	☐ Shiawassee	

Does member have a social risk factor? ☐ Yes ☐ No

Is the member at risk for nutritional deficiency due to food insecurity? ☐ Yes ☐ No

Name of provider referring/submitting form	
☐ I attest that the above information is accurate, and member meets the requirements and medical necessity of the program.	
Signature:	
Name of provider referring/submitting form:	
Full name:	Title:
Email address:	
Phone number :	Date:

Email completed form to **uhcmimedicaidnutrition@uhc.com**

Documentation

It's recommended you send 1 or more of the following documents with this request to support the medical necessity of the recommended service:

- Documentation/office visit notes with diagnosis or identification of chronic illness requiring special diet
- Skilled nursing discharge plan
- Documentation from support agencies indicating services/supports member needs or receives
- Emergency department, inpatient or skilled nursing discharge paperwork
- Medication/treatment orders

This service provides up to 2 meals per day and/or Produce Prescription food (ex., a voucher) services for up to 12 weeks if medically necessary. Meals/food are not provided to respond solely to food insecurity.

Exclusions: Receiving other meal delivery services from local, state or federally funded programs. Enrollees who have the capacity to shop and cook for themselves or have adequate social support to meet these needs.

United Healthcare® Community Plan