Provider Order Form for Medically Tailored Meals

I declare that the following information is true and correct:

1. I am a physician, registered dietitian (RD), clinical nurse specialist (CNS), nurse practitioner (NP), pharmacist, or physician assistant (PA) certifying the member's nutrition-sensitive health condition.
2. I attest that the Medi-Cal member listed below would benefit from medically tailored meals services.

Member Information

Member last name:

Member ID#/CIN#:

Provider Information

☐ Provider order signed by a licensed health care provider or other appropriate clinician, such as a physician, registered dietitian (RD), clinical nurse specialist (CNS), nurse practitioner (NP), pharmacist physician assistant (PA).

Provider type:

Provider name:
(print)

Provider signature: Date: