

## **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:

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