Health Plan Member Application

This form is ***only intended for health plan members*** *of Blue Shield. For other applicants, please refer to the Home-Delivered Meal referral form.*

1. CLIENT INFORMATION

Name (Last, First): _____ Date of Birth: _____

Phone Number: _____ Email: _____

Secondary Contact (if any): _____ Secondary Contact Phone: _____

Address: _____ City: _____ Zip Code: _____

Primary Language: ☐ English ☐ Spanish Other: _____

2. HEALTH PLAN INFORMATION

Medical Insurance: ☐ Blue Shield CIN # _____

Insurance policy number: _____ Insurance Plan/Coverage: _____

3. ELIGIBILITY CRITERIA

Our program is not solely a response to food insecurity, nor is it intended to be a permanent solution. This service provides medically tailored meals for up to 12 weeks.

Diagnosis: – Check all that apply

☐ Chronic condition(s)*: (specify) _____ Provide ICD-10 Code(s): _____

☐Recently discharged from hospital or skilled nurse facility. Date of discharge: _____

☐ At risk of hospitalization or nursing facility placement ☐ Extensive care coordination needs

☐ Other**(specify): _____

4. SERVICE TYPE/DURATION

Type of Request: ☐ Meals ☐ Nutritional assessment/Counseling Session

Term of intervention (four to twelve weeks)_____ weeks

DIETARY RESTRICTIONS

☐ DASH (Heart-Friendly) ☐Diabetic ☐ Renal ☐ Low Potassium

Dietary Restrictions: _____ Food Allergies: _____

5. REFERRAL VERIFICATION

Referral Signature: _____

Date: _____ Print Name: _____

Title: LCSW / MD / NP / RD / PA / Other (specify): _____ (if other attach letter of diagnosis)
Agency / Clinic / Hospital Name: _____

Email: _____ Phone: _____ Fax: _____

Please submit completed form to secure@mamaskitchen.org or by fax to 619-233-6283

*Such as diabetes, congestive heart failure, stroke, chronic lung disorders, HIV, cancer, gestational diabetes, chronic or disabling mental/behavioral health disorders
** If other is selected, please keep in mind client may not qualify