New Mexico Medicaid – Home Delivered Meal Service Referral Form

Food is Medicine for Pregnant Members with diabetes (gestational, type I and or type II)
Standardized for Use Across All MCOs and Vendors

Pregnancy Code: _____ (Z Code)

Diagnosis Code:_____ (Type 1, Type 2, or Gestational Diabetes)

Provider/facility to complete

Managed Care Organization (check appropriate payer)

☐ Blue Cross Blue Shield of New Mexico ☐ Molina Healthcare of New Mexico
☐ Presbyterian Health Plan ☐ United Healthcare of New Mexico

Referral Submitted By:

- Name of referring individual:
  _____
- Organization Name: _____ (e.g., /Clinic/Community Org.)
- Phone: _____ Email:_____

Member Meal Information

- **Name:** _____
- **Medicaid ID #:** _____ (Molina, PHP)
- **Member/Subscriber ID #:** _____ (BCBS, UHC, PHP)
- **Date of Birth:**_____
- **Street Address:** _____ Apt/Unit: _____
- **City:** _____ **State:** NM **ZIP Code:** _____
- **Primary Phone Number:** _____
- **Email Address:** _____
- **Gender and or preferred pronouns:** ☐ She/Her/ Hers (Female) ☐ Him/Him/ His (Male) ☐ They/Them (Gender neutral) ☐ Unknown
- **Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____
- **SNAP/WIC**: Is the member receiving SNAP or WIC benefits?

  ☐ Yes ☐ No

Secondary Contact (if Member is unreachable)

- **Name:** _____
- **Relationship to Member:** _____
- **Primary Phone Number:** _____
- **Email:** _____

Select appropriate meal provider:

☐ Mom's Meals ☐ Homestyle Direct

☐ Meals on Wheels NM ☐ Other Approved Vendor _____

Default Menu Option will be "Diabetes-Friendly", any dietary needs or food preferences list below:

Allergens (check all that apply):

☐ **Dairy** ☐ **Fish** ☐ **Shellfish** ☐ **Tree Nuts** ☐ **Sesame** ☐ **Dark Greens**
☐ **Egg** ☐ **Peanut** ☐ **Soy** ☐ **Wheat** ☐ **Citrus** ☐ **Coconut** ☐ **Chile**
☐ **Other** _____

Food Preferences (optional):

☐ **Vegetarian** ☐ **No Pork** ☐ **No Mushrooms** ☐ **No Strawberry** ☐ **Other – list below**

Special delivery instructions, food-texture modification, other food preferences, religious and/or cultural considerations, and other food locations for rural areas:

Program Type (select one):

☐ **Medically Tailored Meals:** Up to 2 meals per day

- Number of meals/day: Select

- Meal Benefit Start Date _____

- Meal Benefit Duration In Weeks (Remaining Pregnancy + 8 Weeks Postpartum): _____

- Member's Anticipated Due Date: _____

☐ **Medically Tailored Grocery Box**: One box per week totaling no more than 14 Meals

- Number of meals/day: Select

- Grocery Benefit Start Date _____

- Grocery Benefit Duration In Weeks (Remaining Pregnancy + 8 Weeks Postpartum): _____

- Member's Anticipated Due Date: _____

Instructions for Submission:

Send completed form directly to the Member's Managed Care Organization

BCBS - support@virtualhp.com

MHC - molina_nm_foodismedicine@molinahealthcare.com

PHP - foodismedicine@phs.org

UHC - nm_healthequity@uhc.com

For MCO please send completed form to the following selected vendor:

Instructions for Submission:
Verify the completed referral form and submit them to the selected meal provider.

Mom's Meals – ctintake@momsmeals.com (866-224-9485)

Homestyle Direct-dataentry@homestyledirect.com (866-735-0921)

Meals on Wheels New Mexico-clients@mow-nm.org (505-808-6325)

Other Approved Vendor: _____