Anoka County
ALTERNATIVE OR SPECIAL DIET REQUEST

This form MUST be completed by the participant's MN Healthcare Provider (MHCP) physician or nurse practitioner prescribing the special diet on an annual basis.

Plan Start Date: **Plan End Date:**

Participant Name PMI Date of Birth

Case Manager Support Planner (if applicable)

Evaluation of Special Diet

Prescribed Diet(s): If multiple diets are checked, please indicate if they overlap with respect to their dietary components. This will help determine the allowed amount to be claimed for reimbursement.

Prescribed Diet	Do Diets Overlap?	
☐ Anti-Dumping	Yes ☐	No ☐
☐ Gluten Free	Yes ☐	No ☐
☐ Controlled Protein (40-60 grams/requires special products)	Yes ☐	No ☐
☐ Controlled Protein (less than 40 grams/requires special products)	Yes ☐	No ☐
☐ High Protein (minimum 80 grams per day)	Yes ☐	No ☐
☐ High Residue	Yes ☐	No ☐
☐ Hypoglycemic	Yes ☐	No ☐
☐ Ketogenic	Yes ☐	No ☐
☐ Lactose Free	Yes ☐	No ☐
☐ Low Cholesterol	Yes ☐	No ☐
☐ Pregnancy and Lactation	Yes ☐	No ☐

The MHCP enrolled provider must INITIAL each box below for reimbursement to be allowed.

_____ The special diet is NOT considered experimental for the condition being treated.

_____ The special diet is NOT contraindicated (should not be used) for the condition being requested.

_____ The special diet IS appropriate for this individual.

_____ This request is within the scope of my practice.

_____ This individual is currently under my care.

Length of Prescribed Diet(s): _____

Condition Diet is Treating: _____

Notes:

_____ _____

MHCP Enrolled Provider Signature Date

_____ _____

MHCP Enrolled Provider (Printed Name) MHCP Provider Number