



# 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.

Dr. should select appropriate diet (s) and indicate whether foods overlap.

If diets overlap, can only use one diet in budget. If not, may use both diets.

**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

MHCP Provider **MUST** initial.

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

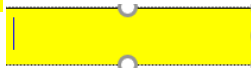
- \_\_\_\_\_ The special diet is NOT considered experimental for the condition being treated.
- \_\_\_\_\_ The special diet is NOT contraindicated (should not be used) for the condition being requested.
- \_\_\_\_\_ The special diet IS appropriate for this individual.
- \_\_\_\_\_ This request is within the scope of my practice.
- \_\_\_\_\_ This individual is currently under my care.

Length of Prescribed Diet(s): \_\_\_\_\_

Condition Diet is Treating: \_\_\_\_\_

**Must be signed by MHCP physician, physician assistant, or nurse practitioner.**

**Notes:**



\_\_\_\_\_  
MHCP Enrolled Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
MHCP Enrolled Provider (Printed Name)

\_\_\_\_\_  
MHCP Provider Number