

## 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 #:** \_\_\_\_\_ (Optional)
- **Member/Subscriber ID #:** \_\_\_\_\_ (Required)
- **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 and menu:**

☐ Mom's Meals☐ Homestyle Direct☐ Meals on Wheels NM

	Meal Type		Meal Type		Meal Type
<input type="checkbox"/>	General Wellness	<input type="checkbox"/>	General Wellness	<input type="checkbox"/>	General Wellness
<input type="checkbox"/>	Heart Friendly/ Low Sodium	<input type="checkbox"/>	Heart Friendly	<input type="checkbox"/>	Heart Friendly
<input type="checkbox"/>	Protein Plus	<input type="checkbox"/>	Low Sodium	<input type="checkbox"/>	Diabetes Friendly
<input type="checkbox"/>	Renal Friendly	<input type="checkbox"/>	Low sodium and Low Fat	<input type="checkbox"/>	Renal Friendly
<input type="checkbox"/>	Diabetes Friendly	<input type="checkbox"/>	Power Packed	<input type="checkbox"/>	Vegetarian
<input type="checkbox"/>	Gluten Free	<input type="checkbox"/>	Renal Friendly		
<input type="checkbox"/>	Pureed	<input type="checkbox"/>	Diabetes Friendly		
<input type="checkbox"/>	Vegetarian	<input type="checkbox"/>	Gluten Restricted		
		<input type="checkbox"/>	Vegetarian		<b>Texture</b>
				<input type="checkbox"/>	Pre-cut/Diced
				<input type="checkbox"/>	Softened/Riced
				<input type="checkbox"/>	Pureed

**Allergens (check all that apply):**

- ☐ Dairy    ☐ Fish    ☐ Shellfish    ☐ Tree Nuts    ☐ Sesame    ☐ Dark Greens  
☐ Egg    ☐ Peanut    ☐ Soy    ☐ Wheat    ☐ Citrus    ☐ Coconut    ☐ Chile  
☐ Other \_\_\_\_\_

**Food Preferences (optional):**

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

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

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**Program Type (select one):**

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

- Number of meals/day: \_\_\_\_\_

- Meal Benefit Start Date \_\_\_\_\_

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

- Member's Anticipated Due Date: \_\_\_\_\_

☐ **Medically Tailored Grocery Box:** One week of meals, no more than 14 Meals

- Number of meals/day: \_\_\_\_\_

- 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](mailto:support@virtualhp.com)

MHC - [molina\\_nm\\_foodismedicine@molinahealthcare.com](mailto:molina_nm_foodismedicine@molinahealthcare.com)

PHP - [foodismedicine@phs.org](mailto:foodismedicine@phs.org)

UHC - [nm\\_healthequity@uhc.com](mailto:nm_healthequity@uhc.com)

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

**Instructions for Submission:**

Include the approved authorization number and referral form and submit them to the selected meal provider.

Mom's Meals – [ctintake@momsm meals.com](mailto:ctintake@momsm meals.com) (1-866-224-9485)

Homestyle Direct-[dataentry@homestyledirect.com](mailto:dataentry@homestyledirect.com)

Meals on Wheels New Mexico-[clients@mow-nm.org](mailto:clients@mow-nm.org)