MUNSON DIALYSIS CENTER

A Service of MUNSON MEDICAL CENTER

Certificate of Medical Necessity For Medical Nutrition Therapy Referral - Chronic Kidney Disease

Patient Name: _____ Date of Birth: _____

Phone: _____

PATIENT DIAGNOSIS:

_____ Chronic Kidney Disease , Stage 1

_____ Chronic Kidney Disease, Stage 2

_____ Chronic Kidney Disease, Stage III (moderate) N18.3 **ICD9: 585.33**

_____ Chronic Kidney Disease, Stage IV (severe) N18.4 **ICD9: 585.4**

_____ Chronic Kidney Disease, Stage V N18.5 **ICD9: 585.5**

_____ End Stage Renal Disease

Diabetes ____ Type 1 ____ Type 2

_____ with diabetic nephropathy:

- **____ intercapillary glomerulosclerosis**
- **____ intracapillary glomerulonephrosis**
- **____ Kimmelstiel-Wilson disease**

_____ with diabetic chronic kidney disease (specify stage above)

_____ Hypertensive chronic kidney disease with stage 5 or ESRD (specify stage above)

_____ Hypertensive chronic kidney disease with stage 1 – 4 CKD (specify stage above)

_____ Other _____

Diet Order:_____

_____ **_____**

Physician Name (Please Print) **Physician Signature (Required)**

Date/Time: _____ **NPI: _____**

Munson Dialysis Department
Phone: (231) 935-0447 **FAX:** (231) 935-0467