

Procedures for submitting referrals for Medicare Advantage meal benefits requiring precertification

Amerigroup has implemented several different supplemental meal benefits on a number of its plans. Some of these benefits require prior authorization to confirm member eligibility. These are benefits not covered by Medicare but are covered under the Medicare Advantage plan. Please refer to the *Evidence of Coverage (EOC)* for details on the specific benefit level.

Benefits that require a referral for prior authorization include:

Benefit	Description of requirement
Healthy meals — post-discharge*	<ul style="list-style-type: none"> • Meals provided to members within 30 days after an overnight stay at a hospital or skilled nursing facility — generally unlimited occurrences of this benefit, but number of meals provided may vary • Amerigroup automatically generates a daily file of members that is sent to GA Foods for this benefit based on internal information for members who are eligible and are not on the <i>Do Not Call (DNC)</i> list • GA Foods will conduct outreach to these members to set up this benefit
Healthy meals — chronic condition*	<ul style="list-style-type: none"> • Meals available for members diagnosed with a chronic condition and recommend by a physician • Currently available on end stage renal disease chronic special needs plans (CSNPs) and select plans • Meal duration varies by plan
Healthy meals*	<p>For individual Medicare Advantage/Medicare Part D (MAPD) plans, this benefit covers up to 16 meals per qualifying event and allows up to four events per calendar year. For Government Retiree Services (GRS) members, the benefit is either 14 or 28 meals over four events.</p> <p>Qualifying events include:</p> <ul style="list-style-type: none"> • Post-discharge within 30 days (additive to any post-discharge meal benefit) • BMI > 25.0 • BMI < 18.5 • HbA1c > 9.0

* Not all benefits are available in all markets. Check the member’s *EOC* for additional information.

To request a referral on behalf of a member, contact Provider Services via:

- Phone and provide information verbally.
- Fax using the fax form below at the following numbers:
 - Individual Medicare Advantage/MAPD plan: **1-866-959-1537**
 - GRS plan: **1-866-959-1537**

Note: For all meal benefits, it is mandatory that the member is not on the *DNC* list, or they give Amerigroup and its agents/vendors permission to contact the member regarding logistics of their meal delivery.

<https://providers.amerigroup.com>

Referral for Individual Medicare Advantage/MAPD or GRS Meal Delivery Benefit

To request meal benefits for a plan member, please complete this form and fax to:

- **1-866-959-1537** for individual Medicare Advantage/Medicare Part D (MAPD) plan.
- **1-866-959-1537** for Government Retiree Services (GRS) plan.

Member name:		DOB:	
Health plan member ID:		Phone #:	
Delivery address:			
Delivery city:		Delivery state:	
		Delivery ZIP code:	
Meal request information (check as appropriate):			
<input type="checkbox"/> Post-discharge meal benefit		Date of discharge:	
<input type="checkbox"/> Chronic meal benefit			
<input type="checkbox"/> Healthy food deliveries benefit (individual or GRS) — member has been clinically assessed and determined to have nutritional needs based on post-discharge status, BMI score > 25 or < 18.5, or HbA1c score > 9.0			
<input type="checkbox"/> Prescribed meals — member has been clinically assessed and determined to have nutritional needs based on a chronic condition, BMI score > 25 or < 18.5, or congestive heart failure			
Chronic condition:			
HbA1c score:		BMI score:	
Dietary/meal information:			
Medical dietary restrictions including allergies, cultural and so on (for example, gluten free):			
Prescribed medications with food contraindications (for example, Coumadin):			
I certify that this member is under my care, meets the conditions described above and is utilizing this benefit to ameliorate a health condition or help to avoid emergency health care utilization:			
Licensed medical professional name:			
License #:			
Signature:			
Date:		Phone #:	
Office staff contact name:			
Note: Member must be able to provide consent to be contacted to fulfill this benefit (if on the <i>Do Not Call</i> list)			
Member consent to be contacted:			
As a beneficiary under the above plan, I realize that I will be contacted by my health plan or one of its agents to verify nutritional information and arrange for delivery of my meals. I hereby consent for the health plan or one of its agents to contact me at the number provided below.			
Member name:		Phone #:	

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