American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

REFERRAL FOR NUTRITION SERVICES

For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATION MANAGER

Patient Name__________________ (Last / First / Initial) Gender: M / F Birthdate__________ (mm/dd/yyyy) Patient ID#__________

Patient Address__________________ City/State/Zip__________________

Patient Phone (____)__________ Subscriber Name__________________ Subscriber ID#__________

Health Plan__________ ☐ Primary ☐ Secondary Employer__________ Group #__________

Referral From:	Referral To:
Clinic Name__________	Clinic Name__________
Referring Physician/Practitioner Name: __________	Practitioner Name__________
Office Contact for this Referral__________	Address__________
Address__________	City/State/Zip__________
City/State/Zip__________	Phone (______)__________
Phone (______)__________	Fax (______)__________
Fax (______)__________	

PLEASE PROVIDE NUTRITION SERVICES FOR THE FOLLOWING CONDITION(S):

- ☐ Diabetes type 1 or 2 (circle type)
- ☐ Cardiovascular disease – list type__________________
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Other – please specify__________________

Comment/Special Instructions:

____

____

____

____

____

Distribution:

1. Keep original in patient's file.
2. Give a copy to the Patient to take to the Practitioner of Nutrition Services.
3. Fax a copy to ASH Group at the fax number above.

Signature of referring physician/practitioner__________________ **Date**__________