



Service Authorization Request

For L.A. Care Medi-Cal and L.A. Care Medicare Plus (HMO D-SNP) Members Only Fax to 1-213-536-0638 Email: mealsasmedicine@lacare.org

Eligibility (Population Subset)

- 1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
- 2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
- 3. Individuals with extensive care coordination needs.

NOTE: Meals are not covered to respond solely to food insecurities. Referrals must be medically necessary.

Please select request type. Signature required on page 2 by referring entity. (primary care doctor signature preferred, but not required) Routine Request Urgent Request (72-hour processing) Post-Discharge (72-hour processing)
Member information
Line of Business: Medi-Cal L.A. Care Medicare Plus (HMO D-SNP)
Medicaid ID Number Member DOB Member Phone
M M / D D / Y Y Y Y
First Name Last Name
Member's Address & Language preference are on file with L.A. Care and will be used to process this request. Any updates must be completed by contacting Customer
Service 24 hours a day-7 days a week at 1-888-839-9909 for Medi-Cal or at 1-833-522-3767 for D-SNP members
Caregiver Contact information & Official Designation Title
First Name: Last Name:
Phone Number: Title / Relationship:
Referring Entity
Please select entity type. Referring entities with an asterisk (*) must provide their NPI below.
PCP / Specialist* Skilled Nursing Facility* Community Supports Provider* Community Based Adult Services
Hospital*
Other:
Internal L.A. Care Entity:
Behavioral Health Care Management Customer Solution Center
Utilization Management Managed Long Term Services & Supports (MLTSS) Pharmacy
Other:
Referring Entity NPI (if available) Phone Ext. Fax
Referring Entity Name
Address
City Zip LAC Provider ID
Email

Please use an In-Network Provider NPI & Provider ID if available to complete this form. Find these at: https://www.lacare.org/find-doctor-or-hospital





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Checking this box attests that Program Eligibility for Extra Benefits & Services have been discussed and have receive clinical & supportive documentation from qualified clinical practitioner with direct knowledge and treatment responsi		
Chronic Health Conditions		
 Attention: The following bulleted conditions require that this form be signed by the member's treating possible. All pediatric requests (under 18 years) Gestational diabetes High-risk perinatal / postpartum conditions Mental / Behavioral health of the physical & Cognitive Disabileters Conditions not listed in the properties of t	conditions	
Select from the conditions below, and add any available lab values. If condition is not listed, please add in corresponding ICD-10 code.	the diagnosis section below. Include	
Diabetes Cardiovascular Disorders ☐ Type I ☐ Type II ☐ Gestational Diabetes ☐ Congestive Heart Failure Last A1c Value: ☐ Date: ☐ Hyperlipidemia	Stroke Hypertension	
Chronic Kidney Disease Stage 3 Stage 4 End-Stage Renal Disease / Dialysis Last eGFR Value: Date: Triglyceride Level:	Date:	
Other Diagnosis / Health Condition 1	ICD-10 Code	
Other Diagnosis / Health Condition 2	ICD-10 Code	
	•	
Please submit any clinical notes or other documentation in support of this referral. This includes available lab values.		
Diet Requested		
Please select one of the following diet request types: Therapeutic Diet Prescription: a diet request that is part of a post-discharge order or a provider treatment plan. Please attach or note the dietary plan requested below. Request for an L.A. Care Registered Dietitian to select a meal plan that is most appropriate for the member's health and dietary needs.		
Please list any food allergies, intolerances, dietary needs or prescription order below (if any)		
Exclusions		
 Members with any of the following limitations are not eligible. Please confirm with member. Member is currently in another MTM program Member is unable to receive home-delivered meals Member is unable to store or prepare meals for consumption Member has a severe food allergy or intolerance Check this box to confirm that the member does not have any of the exclusion criteria listed above.		
Please note any additional comments below (if any)		
Referrer Signature Date Signed		