PRESBYTERIAN
Health Plan, Inc.

New Mexico Medicaid- *Food is Medicine* for Pregnant Members with Diabetes
Home Delivered Meal Service Referral Form

Standardized for use across all MCOs and Vendors

Referral Date _____

Member Information

First Name _____ Pronouns ☐ She/Her ☐ He/Him
Last Name _____ ☐ They/Them ☐ Other _____
Preferred Name _____ DOB _____

Turquoise Care Managed Care Organization (MCO):

☐ Blue Cross Blue Shield of New Mexico (BCBS) ☐ Presbyterian Health Plan (PHP)
☐ Molina Healthcare of New Mexico (MHC) ☐ United Healthcare of New Mexico (UHC)

Medicaid ID # (MHC, PHP) _____
Member/Subscriber ID # (BCBS, UHC, PHP) _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Asked but no answer ☐ Unknown

Race ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ Other ☐ Native Hawaiian or other Pacific Islander ☐ White

Preferred Language ☐ English ☐ Spanish ☐ Other (Specify) _____
SNAP/WIC Benefits ☐ Yes, currently receiving ☐ No, referral needed ☐ No, referral declined

Delivery Information

Street Address _____ Apt/Unit _____
City _____ State _____
County _____ Zip Code _____
Phone Number _____ Email _____

Secondary Contact (if Member is unreachable)

Name _____ Relationship to Member _____
Phone Number _____ Email _____

Special Delivery Instructions (if needed), such as other delivery locations for rural areas or PO Boxes

Pregnancy Information (Member must be currently pregnant or less than 8 weeks postpartum AND have diabetes diagnosis)

Estimated Due Date (EDD) _____ Baby's DOB (if delivered) _____
Gestational Age (GA), weeks _____ Estimated Length of Benefit (48 - GA *or* 8 - #wks Postpartum) _____ weeks
Pregnancy Z Code _____ Type 1, Type 2, or GDM Dx Code _____

Referred by

Name _____ Title _____
Organization _____
Contact Phone number _____ Email _____

Meal Information

Meal type (Choose one. Member *may* be able to change selection with meal vendor during the benefit period.)

☐ Medically Tailored Meals ☐ Medically Tailored Grocery Box

Number of Meals per day

☐ 1 per day ☐ 2 per day

Menu ☑ Diabetes Friendly

Allergies (Select all that apply)

☐ Eggs ☐ Fish ☐ Gluten/Wheat ☐ Milk
☐ Peanut ☐ Sesame ☐ Shellfish ☐ Soy
☐ Tree Nuts ☐ Other (Please list) _____

Preferences (Optional)

☐ Vegetarian ☐ Vegan ☐ No Pork ☐ Other (list in box below)

Please list other menu modifications needed, such as textures, religious/cultural considerations or other preferences:

Meal Provider Selection

☐ Homestyle Direct ☐ Meals on Wheels ☐ Mom's Meals
☐ No Preference, MCO Select ☐ Other Approved Provider _____

Instructions for Referring Party to Complete Referral

Send completed form directly to the Member's Turquoise Care Managed Care Organization (MCO)

BCBS support@virtualhp.com
MHC molina_nm_foodismedicine@molinahealthcare.com
PHP foodismedicine@phs.org
UHC nm_healthequity@uhc.com

For MCO USE ONLY

Verify referral information for errors or missing information

Submit form to selected meal provider

☐ Homestyle Direct dataentry@homestyledirect.com (866) 735-0921
☐ Meals on Wheels NM clients@mow-nm.org (505) 808-6325
☐ Mom's Meals ctintake@momsmeals.com (866) 224-9485
☐ Other Approved Vendor _____

Date Referral Submitted to Meal Provider _____

MCO Staff Submitting to Meal Provider _____