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:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description of requirement</th>
</tr>
</thead>
</table>
| Healthy meals — post-discharge*              | • 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 Do Not Call (DNC) list  
  • GA Foods will conduct outreach to these members to set up this benefit |
| Healthy meals — chronic condition*          | • Meals available for members diagnosed with a chronic condition and recommended 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*                               | 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.  
  Qualifying events include:  
  • 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.
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):

☐ Post-discharge meal benefit  Date of discharge: _______________________
☐ Chronic meal benefit

☐ 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

☐ 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 Do Not Call 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 #: ___________________________