Medical Nutrition Therapy (MNT) Superbill

Date of Service:	Provider name:
Patient name:	Tax ID#:
Address:	NPI:
Phone:	License #:
DOB:	
Referring Provider Name:	Referring provider NPI:

Diagnoses					
✓	**ICD-10**	**ICD-10 Description**	✓	**ICD-10**	**ICD-10 Description**
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

Office Procedure			
✓	**CPT Code/Description**	**Units**	**Fee**
☐			
☐			
☐			
☐			
☐			
☐			

Total Charge	
Amount Paid	
Balance Due	

RDN Name:_____

RDN Signature: _____