bedard MEDICAL SUPPLIES

Phone: 207-784-3700
Fax: 207-795-7622

CERTIFICATE OF MEDICAL NECESSITY
CONTINUOUS GLUCOSE MONITORING

☐ Dexcom G6	☐ Other:_____	☐ Transparent Dressings (1 Year)	☐ IV Prep Wipes (1 Year)
☐ Sensors (A9276/K0553) (365/365 1 unit = 1 day) Directions for use: site change per manufacturer recommendation, up to 90 day supply unless otherwise noted			
☐ Transmitters (A9277/K0553) (4/365)	☐ Receiver (A9278/K0554) (1/365)		

PATIENT INFORMATION	
Patient Name:	Gender:
Address:	DOB:
City/State/Zip:	Phone:

STATEMENT OF MEDICAL NECESSITY			
# Multiple Daily Injections per day		# SMBG/day to per day	
On Insulin Pump? ☐ Yes ☐ No	Start Date:	Fluctuation of blood glucose values:	
HbA1C:	Date:	Between mg/dl mg/dl	
Fasting Hyperglycemia mg/dl	Date:	Currently on CGM Therapy? ☐ Yes ☐ No	# of refills: 12
Current Diagnosis and Diabetic Complications			
Insulin: ☐ Z79.4 **Type 1:** ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 **Additional diagnosis:**_____			
Complications/Insulin Reaction Notes:			

SUPPORTING CLINICAL INDICATIONS
☐ A. History of hypoglycemia unawareness
☐ B. History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements.
☐ C. History of nocturnal hypoglycemia
☐ D. Recurring episodes of severe hypoglycemia
☐ E. Evidence of unexplained severe hypoglycemia
☐ F. Patient has been hospitalized or has required paramedical treatment for low blood sugar
☐ G. Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dl
☐ H. Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections
☐ I. History of suboptimal glycemic control before or during pregnancy
☐ J. Poor glycemic control as evidenced by 72 hour CGMS sensing trial
☐ K. Multiple alterations in self-monitoring and insulin administration regimens to optimize care
☐ L. Patient and/or caregiver has completed comprehensive diabetes education
☐ M. Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
☐ N. Patient is motivated to achieve and maintain improved glycemic control

PHYSICIAN INFORMATION	
Physician:	Office Contact:
Hospital/Clinic:	Phone #:
Address:	Fax #:
City/State/Zip:	NPI #:

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Continuous Glucose Monitoring Device and supplies.

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Signature:_____ Date:_____