

Diabetic Testing Supplies Detailed Written Order

1. Patient Information

Patient Name: _____ DOB: _____ Phone #: _____
 Is patient currently in a facility? Y N If yes, Facility Name: _____ Facility Phone #: _____
 Patient Face Sheet/Demographics & Chart Notes Included

2. Provider Information

Provider Name: _____ NPI #: _____ Phone #: _____
 Fax #: _____ Date of most recent face-to-face exam: _____

3. Diagnosis Information

ICD-10 Code: E10.9 Type 1 Diabetes Mellitus without Complications E10.65 Type 1 Diabetes Mellitus with Hyperglycemia
 E11.9 Type 2 Diabetes Mellitus without Complications E11.65 Type 2 Diabetes Mellitus with Hyperglycemia
 Other: _____

4. Supporting Criteria

- Do you treat this patient for diabetes? Y N
- Does this patient use injected insulin for diabetes control? Y N
- Are you maintaining medical records reflecting the care provided, but not limited to, evidence that the prescribed frequency of testing is reasonable and necessary? Y N
- Has the patient (or patient's caregiver) successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices? Y N
- Is the patient (or patient's caregiver) capable of using the test results to assure the patient's appropriate glycemic control? Y N
- Is the device designed for home use? Y N
- What is the frequency of glucose testing per day?
Non-Insulin Dependent Patient: 1 time daily 1-2 times daily 2 times daily Other: _____
Insulin Dependent Patient: 1 time daily 1-2 times daily 2 times daily 2-3 times daily 3 times daily 3-4 times daily
 4 times daily Other: _____
- If this is a refill order, approximately how many test strips/lancets remain? _____

5. Physician's Order / Prescription

Item	Brand & Model (If Medicare, Embrace brand only)	Dispense Qty	Refill Qty	Directions for Use (Sig)
Glucose Monitor (E0607)				<input type="checkbox"/> Use as directed to test glucose. <input type="checkbox"/> Other:
Test Strips (A4253)				<input type="checkbox"/> Use to test glucose _____ per day. <input type="checkbox"/> Other:
Lancets (A4259)				<input type="checkbox"/> Use to collect blood sample. <input type="checkbox"/> Other:
Control Solution (A4256)				<input type="checkbox"/> Use to test the accuracy of the meter up to once weekly <input type="checkbox"/> Other:
Lancing Device (A4258)				<input type="checkbox"/> Use per package instruction to collect blood sample <input type="checkbox"/> Other:
Alcohol Prep Wipes				<input type="checkbox"/> Use to clean the skin before using lancet. <input type="checkbox"/> Other:
Other:				

Patients who are **not currently being treated with insulin** injections, up to **100 test strips** and up to **100 lancets** or one lens shield cartridge is covered every **3 months**.
 Patients who are **currently being treated with insulin** injections, up to **100 test strips** and up to **100 lancets** or one lens shield cartridge is covered **every month**.

If refills of quantities of supplies exceed utilization guidelines, documentation that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed must be present in the physician's and supplier's records.

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for diabetic testing supplies. I certify that I am the provider 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.

Provider Signature: _____ Date: _____