

# 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

1. Do you treat this patient for diabetes?  Y  N
2. Does this patient use injected insulin for diabetes control?  Y  N
3. 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
4. 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
5. Is the patient (or patient's caregiver) capable of using the test results to assure the patient's appropriate glycemic control?  Y  N
6. Is the device designed for home use?  Y  N
7. 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: \_\_\_\_\_
8. 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: \_\_\_\_\_