directDiabetes

PHYSICIAN ORDER FOR DIABETES SUPPLIES

Start Date:_____ Referred By: _____

Name: _____ ☐ Male ☐ Female Birthdate: ____ / ___ / _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: (___)_____ Home Phone: (___)_____ SS #: _____/_____/_____

INSURANCE (check all applicable insurances)

PRIMARY INSURANCE ☐ MEDICARE ☐ BC/BS ☐ Health Choice ☐ Other:_____

Contract Policy # _____ Group # _____ Subscriber: _____

SECONDARY INSURANCE ☐ Medicaid ☐ Other_____

Contract Policy # _____ Group # _____ Subscriber: _____

1 IS PATIENT TREATED WITH INSULIN?

☐ YES ☐ NO

2 SUPPLIES NEEDED

(please cross out those items not authorized for this patient)

Monitor: has/needs Brand: _____

Test Strips Lancets Control Solution

Batteries Lancing Device Other_____

3 DURATION OF NEED

☐ 12 Months ☐ Lifetime

4 RECOMMENDED TESTING

☐ 1XDay ☐ 2XDay ☐ 3XDay

☐ 4XDay ☐ 5XDay ☐ 6XDay

☐ Other _____

5 DIAGNOSIS

☐ 250.01 Type 1 ☐ 250.00 Type 2 controlled

☐ Other ☐ 250.02 Type 2 uncontrolled

I have documented in the patient's medical record the # of times testing and the reason for high testing as:

☐ Fluctuating Blood Glucose ☐ Hypoglycemia

☐ Hypertension ☐ Uncontrolled Blood Glucose

☐ Other

6 SIGNATURE & DATE

Physician Signature: _____ Date: _____

Physician Name: _____ NPI #_____

Address:_____ License #_____

_____ Phone # (_____)_____

_____ Fax #(_____)_____

PLEASE FAX TO 480-998-5247 OR 1-866-439-4694

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