



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

P.O. Box 4907 • Scottsdale, Arizona, 85261 • Phone: 480-998-5551 or 1-888-880-8378 • www.DirectDiabetic.com