Reliable DIABETES CARE
New England DME Supplier

CERTIFICATE OF MEDICAL NECESSITY

Complete and fax back to (781) 987-8206

PATIENT INFORMATION (PLEASE INCLUDE DEMOGRAPHIC SHEET AND LAST OFFICE VISIT NOTE)

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **Phone Number:**_____

ORDER INFORMATION

Order Start Date: _____ Length of Need: *Lifetime unless noted* _____

ICD-10 Dx Code: ☐E10.9 ☐E10.65 ☐E11.9 ☐E11.65 ☐Other: _____

PRESCRIBED ITEMS:

INSULIN PUMP (E0784): ☐Tandem t:slim X2 ☐Beta Bionics iLet Bionic Pancreas ☐Medtronic 780g (includes E0607) ☐Tandem Mobi

INSULIN PUMP SUPPLIES: ☐Infusion Sets(A4230/A4231/A4224) ☐Cartridges(A4232/A4225) ☐Extended Infusion Set (1 per 7 days)

Prescribed site change frequency for insulin pump supplies: ☐ Every 3 days (#30 per 90 Days) ☐ Every 2 Days (#50 per 90 Days) ☐ Every 1.5 Days (#60 per 90 Days) ☐ Every Day (#90 per 90 Days)

If patient changes more frequently than every 3 days, indicate condition as documented in medical records:

☐Skin irritation ☐Scar tissue buildup ☐Allergies ☐Catheter Occlusion ☐Other:_____

CGM Brand: ☐Dexcom G6 ☐Dexcom G7 ☐Libre 3 ☐Libre 2 ☐Libre 14-Day ☐Medtronic Guardian

CGM Components:

☐CGM Receiver/Monitor – E2103 (1 per 5 years)/ E2102 (1 per 5 years) / A9278 (1 per 365 days)

☐CGM Transmitter & Sensors – A4239 (1 per month)/ A4238 (1 per month)/A9277 (1 per 3 month or 1 per year for Medtronic) & A9276 (1 unit per day)

BGM Components:

(IDD, 2 units A4253 and 1 unit A4259 per month; NIDD 2 units A4253 and 1 unit A4259 per 3 months)

☐Blood Glucose Meter (E0607) ☐Blood Glucose Testing Supplies (A4253, A4259)-# of glucose tests/day: ___

☐Lancing Device (A4258) 1 per 6 months

☐Control Solution (A4256) 1 per week

QUALIFICATIONS:

☐ Patient is insulin treated, OR

☐ Patient has a history of problematic hypoglycemia

☐ Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicare-approved telehealth visit with the beneficiary to evaluate their diabetes control

Patient also has/has had a history of the following:

☐Recurring hypoglycemia ☐Severe/unexplained hypoglycemia ☐Hypoglycemic unawareness

☐Nocturnal hypoglycemia ☐Wide fluctuating blood glucose levels and/or severe glycemic excursions

☐Dawn Phenomenon ☐HGBA1C – Result:_____% on ____/____/____

MEDICAL JUSTIFICATION FOR REQUESTED ITEMS: _____

Healthcare Provider Signature: _____ **Date:** _____

Healthcare Provider Name:_____ **NPI:** _____

Healthcare Provider Email Address:_____

Address:_____ **Phone:**_____ **Fax:**_____