FAX: 1-305-455-5700
Questions? 1-866-938-4485

Continuous Glucose Monitoring & Supplies Order Form

Please initial and date any changes made to the order to avoid processing delay.
This form serves as a prescription for CGM and all related diabetes supplies to be provided by US MED.

Effective Date: _____ **CMN:** _____

PATIENT INFORMATION:	ID:	PHYSICIAN INFORMATION:
Name:	D.O.B.:	NPI #:
Address:	Phone: (____) _____	Name:
	Gender:	Address:
		Phone: (____) _____ Fax:(____) _____

Step 1

Diagnosis: ☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.39 ☐ Other:_____

CGM Supplies Requested:

Monthly supply allowance includes all supplies and accessories (1/month):

☑ Sensors	☑ Test Strips	☑ Control Solution	☑ Lancing Device
☑ Transmitter	☑ Lancets	☑ Glucose Meter	☑ Receiver (1/5 yrs)

Length of need: Lifetime – unless specified otherwise

IMPORTANT COVERAGE CRITERIA

The below conditions are required for insurance coverage. These conditions must be included in the patient's **MEDICAL RECORDS THAT INCLUDE ALL OF THE INFORMATION BELOW**, which **MUST BE SENT AND KEPT ON FILE** as supporting evidence.

1. Patient currently checks blood glucose levels 4 or more times a day.
2. Patient currently injects insulin 3 or more times per day or is currently using an insulin pump.
3. The patient's insulin treatment regimen requires frequent adjustment by the patient or caregiver due to self-testing results.
4. The patient has had a doctor visit to evaluate their diabetes control within the last 6 months.

Step 2

Date:_____ /_____ /_____ MM/DD/YYYY

Physician Signature: _____

NPI: _____

Name: _____

If the signature differs from the referring physician, please include your updated NPI number and printed name.

ACHC ACCREDITED

BBB ACCREDITED BUSINESS