Genteel®

NOT FOR MEDICARE COVERAGE

MEDICAL NECESSITY FORM

1. PATIENT INFORMATION

Patient Name	
Date Of Birth	
Address	
Telephone #	

2. INSURANCE DETAILS

Insurance Company					
Telephone #				Fax#	
Address					
Insured's Name					
ID#		Group#		Policy #	

PROVIDERS: PLEASE FILL OUT THE FOLLOWING SECTIONS AND SUBMIT THIS FORM TO YOUR PATIENT'S INSURANCE PROVIDER.
PATIENTS: PLEASE RETAIN A COPY FOR YOUR RECORDS.

3. MEDICAL PROVIDER INFORMATION

Provider Name (print)			
Office/Clinic			
Address			
Telephone #		Fax#	

4. PRODUCT INFORMATION

Genteel Lancing Device (**HCPCS-A4258**) - 1 Standard Kit = $129.00*_____ (*other cost)*
Kit Includes: 1- Genteel Lancing Device & 6- Contact Tips (for controlled depth and comfort)
*this is a one time charge; no additional costs are required to use this device.

5. PATIENT TESTING/A1C INFORMATION

My patient currently tests his/her blood sugar: (circle one)			
1-3 times daily		4-6 times daily	more than 6 times daily
Varies (please explain):			
My patient should test his/her blood sugar: (circle one)			
1-3 times daily		4-6 times daily	more than 6 times daily
Primary reason for not testing as often as directed by provider: (circle one)			
Pain	Cost of supplies	Availability of supplies	Not understanding directions
Other (please explain):			
Patient's most recent HbA1C: (circle one)			
>9.0% mg/dl (CPT II 3046F)		7.0-9.0% mg/dl (CPT II 3045F)	<7.0% mg/dl (CPT II 3044F)

NOTE: Genteel LLC is NOT submitting this billing and is not a CMS-approved healthcare provider with a UPIN. All billing is to be submitted by patient or provider with healthcare information included from medical provider

6. RECENT/CURRENT DIAGNOSES THAT APPLY TO MY PATIENT: (CIRCLE ALL THAT APPLY)

Description of condition	Drug or Chemical Induced DM (E09	Type 1 DM (E10)	Type 2 DM (E11)	Other Specified DM (E13)
Diabetes Mellitus with nephropathy	E09.21	E10.21	E11.21	E13.21
Diabetes Mellitus with diabetic chronic kidney disease	E09.22	E10.22	E11.22	E13.22
Diabetes Mellitus with unspecified diabetic retinopathy with macularedema	E09.311	E10.311	E11.311	E13.311
Diabetes Mellitus with unspecified diabetic retinopathy without macularedema	E09.319	E10.319	E11.319	E13.319
Diabetes Mellitus with other diabetic ophthalmic complication	E09.39	E10.39	E11.39	E13.39
Diabetes Mellitus with polyneuropathy	E09.42	E10.42	E11.42	E13.42
Diabetes Mellitus with other diabetic dermatitis	E09.620	E10.620	E11.620	E13.620
Diabetes Mellitus with hypoglycemia with coma	E09.641	E10.641	E11.641	E13.641
Diabetes Mellitus with hypoglycemia without coma	E09.649	E10.649	E11.649	E13.649
Diabetes Mellitus with hyperglycemia	E09.65	E10.65	E11.65	E13.65
Diabetes Mellitus with other specified complication (_____)	E09.69	E10.69	E11.69	E13.69
Diabetes Mellitus with unspecified complications	E09.8	E10.8	E11.8	E13.8
Diabetes Mellitus without complications	E09.9	E10.9	E11.9	E13.9
Pre-existing DM in pregnancy OR Gestational DM (O24)	https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx?KeyWord=diabetes&bc			
Other Diagnosis				

7. WHY GENTEEL® IS MEDICALLY NECESSARY

The Genteel® Lancing Device has a unique piston design, making it the only FDA-cleared (510K) lancing device that works by drawing blood with vacuum. When used as directed, the lancet pierces just below the skin to reach blood from the layer of capillaries. Without needing to pierce deeper to the nerves, the patient doesn't experience pain, and the vacuum action draws blood up to the surface to be tested with the patient's regular diabetes supplies. Patients often report their primary barrier to testing their blood sugar is PAIN. Genteel® Lancing Device removes this barrier, which is likely to increase patients testing their blood sugars, improving compliance and therefore reducing HbA1c and reducing the numerous complications that come with poorly-managed Diabetes Mellitus.

I certify that Genteel® is Medically Necessary for my patient._____(inital)

8. MEDICAL PROVIDER AUTHORIZATION

I certify this patient has diabetes and is being treated by me. This form reflects the patient's condition and regimen If requested, I am able to provide accurate documentation and my records reflect accurate testing frequency. The patient and/or caregiver are able to follow instructions for controlling diabetes and able to use these requested supplies.

Provider Signature _____ Date: _____

UPIN#: _____

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