



# Diabetes Physician Referral Form

Attention HCP DEPARTMENT

Fax form with physician's signature to **1-800-204-1677**

### PHYSICIAN INFORMATION

Physician Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 UPIN# \_\_\_\_\_  
 NPI# \_\_\_\_\_ DEA# \_\_\_\_\_  
 Medicaid ID# \_\_\_\_\_

### PATIENT INFORMATION

Patient Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Language  English  Spanish  Other \_\_\_\_\_

**INSURANCE INFORMATION**  Medicare  Medicaid  Other \_\_\_\_\_

**PRODUCTS REQUESTED**  Check here if starter kit given in office Meter Serial # \_\_\_\_\_

**Meter**  GlucoLab  Ascensia Breeze II  Ascensia Contour  Other \_\_\_\_\_

**Testing Frequency**  1 time per day  2 times per day  3 times per day  4 times per day  5 times per day  other \_\_\_\_\_

**Insulin-Treated**  Yes  No If yes, type of Insulin \_\_\_\_\_ Directions \_\_\_\_\_ Type of Syringe \_\_\_\_\_

### DIABETES ICD-9 DIAGNOSIS CODES

- 250.00** Type II (unspecified type), not stated as uncontrolled
  - 250.01** Type I (juvenile type), not stated as uncontrolled
  - 250.02** Type II (unspecified type), **Uncontrolled**
  - 250.03** Type I (juvenile type), **Uncontrolled**
  - 369.00** Legally Blind
  - Other \_\_\_\_\_
- Duration of Need** 99 years unless otherwise stated \_\_\_\_\_

### APPROVED MEDICARE SERVICES (please check supplies approved)

- Meter  Strips  Lancets
- Lancing Device  Control Solution  Battery for Meter

Estimated number of strips and lancets provided for a 90-day period:

- 1 time per day = 100  2 times per day = 200
- 3 times per day = 300  4 times per day = 400
- 5 times per day = 500  other \_\_\_\_\_

**Important: Medicare requires a HIGH FREQUENCY REASON** for non-insulin treated patients testing more than 1 time/day and insulin treated patients testing more than 3 times/day:

- Fluctuating Blood Sugar Levels  Change in Medication  Hypertension  Other \_\_\_\_\_

By my signature below I confirm that the patient has diabetes and is being treated by me. Further, the patient has been seen and evaluated for his/her diabetes within six (6) months of this order. All the information contained in this Doctor's Order form accurately reflects the patient's diagnosis of diabetes and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow my instructions and is able to use the ordered items. For Medicare/Insurance requirements, I will maintain this signed original in the patient's medical record file.

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

DPRF\_0307