NationsHealth®

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 ______________________

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

For additional assistance, please contact us at 1-800-978-7578 13650 NW 8th Street Suite 109, Sunrise, FL 33325

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