

Written Order and CMN for Continuous Glucose Monitoring (CGM)

PATIENT INFORMATION:		
Name:		
Address:		
City, ST, Zip:		
Phone:	Date of Birth:	Account #:

DOCTOR INFORMATION:		
Name:		
Address:		
City, ST, Zip:		
Phone:	Fax:	
NPI:	License #:	

PRODUCT INFORMATION <i>(please check the items that you are prescribing):</i>
<p>I am prescribing the following – please check the appropriate manufacturer. <i>[code definitions: A9278/K0554 receiver/reader; A9277 transmitter; A9276/K0553 sensors]</i></p> <p> <input type="checkbox"/> Abbott FreeStyle Libre system A9278/K0554 (qty 1), A9276/K0553 (qty up to 30/month) <input type="checkbox"/> Dexcom system A9278/K0554 (qty 1), A9277 (qty 4), A9276/K0553 (qty up to 30/month) <input type="checkbox"/> Medtronic system A9278 (qty 1), A9277 (qty 2), A9276 (qty up to 30/month) <input type="checkbox"/> Senseonics Eversense system A9277 (qty 2), A9276 (qty up to 30/month) </p> <p>If there are any specific instructions, list here: _____</p>

MEDICAL INFORMATION <i>(please check and/or complete the appropriate responses):</i>
<ol style="list-style-type: none"> 1. YES <input type="checkbox"/> NO <input type="checkbox"/> Has the patient been compliant with their physician-ordered diabetes treatment plan? 2. YES <input type="checkbox"/> NO <input type="checkbox"/> Has the patient been using a home glucose monitor and testing at least 4x per day? 3. YES <input type="checkbox"/> NO <input type="checkbox"/> Is the patient being treated with at least 3 multiple daily insulin injections or using an insulin pump? 4. YES <input type="checkbox"/> NO <input type="checkbox"/> Does the patient need to make frequent adjustments to their insulin? 5. <input type="checkbox"/> Patient experiences hypoglycemia: Frequent <input type="checkbox"/> Overnight <input type="checkbox"/> Diagnosis Code: _____ 6. <input type="checkbox"/> Patient has hypoglycemia unawareness 7. <input type="checkbox"/> Patient experiences (check): Nerve Problems <input type="checkbox"/> Eye Problems <input type="checkbox"/> Loss of Feeling in Feet <input type="checkbox"/> Kidney Problems <input type="checkbox"/> 8. <input type="checkbox"/> Patient has had Glucagon administrations 9. <input type="checkbox"/> Patient has elevated HbA1C (enter the value) _____ 10. <input type="checkbox"/> Patient has been to the emergency room due to complications 11. <input type="checkbox"/> Patient will be supervised by physician and/or diabetes educator 12. <input type="checkbox"/> Patient has been hospitalized for (check): Hypoglycemia <input type="checkbox"/> DKA <input type="checkbox"/> 13. What is the patient's ICD10 diagnosis? _____ 14. What is the date of the patient's last office visit? _____

I certify the medical necessity of these items for this patient. The medical information on this form and any statement on my letterhead attached hereto has been completed by me or my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that my falsification, omission or concealment of material fact may subject me to civil or criminal liability. I certify that I am a physician who manages multiple patients on continuous subcutaneous insulin therapy and work closely with a team of nurses, diabetes educators, and dietitians knowledgeable in insulin pump therapy and evaluating the patient every 3 months.

Physician Signature: _____ <small style="text-align: center;">no stamps please</small>	Date: _____
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or return to: **FAX: (502) 657-0237**

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Website: www.myEHCS.com