CGM PRESCRIPTION FORM

Patient Name: _____ DOB_____

START DATE: _____ REFILLS: LIFETIME (X) OTHER: _____/months

ICD 10 DIAGNOSIS CODE (Must be reflected in Medical Records)

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

Coverage criteria and medical necessity documentation must adhere to current Medicare LCD: L33822
Medical necessity must be documented in Patient's Medical Records in accordance with medicare guidelines.

E2103 Non Adjunctive CGM or Receiver
E2102 Adjunctive CGM or Receiver
1 Unit allowed Once every 5 years

Length of Need: Lifetime-unless specified otherwise:

A4239 CGM sensors and supplies for Non Adjunctive CGM
A4238 CGM Sensors and supplies for Adjunctive CGM
1 Unit/30 Days or 3 Units/90 Days
(1 Unit = 1 month of sensor and supplies)

Length of Need: Lifetime-unless specified otherwise:

Prescribed CGM

☐ Freestyle Libre 2 ☐ Fresstyle Libre 3 ☐ Dexcom G6 ☐ Dexcom G7 ☐ Medtronic Guardian Connect
Other: _____

Current Insulin Regimen (Required to qualify for CGM use)

☐ Insulin Pump ☐ Multiple Daily Injections – Number per day : _____

PHYSICIAN ATTESTATION:

I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness**. The patient and or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other Insurance for post payment review or audits.

PHYSICIAN NAME: _____ NPI # _____ PHONE # _____

PHYSICIAN SIGNATURE_____

Instructions for Referral Submission

Fax or email completed form along with the documents listed below

- Patient Face Sheet (containing current demographics and insurance)
- Medical Record (Must contain the criteria required by Medicare LCD L33822 has been met/documented)

PH# 866-748-5151 FAX# 866-634-8166 EMAIL: Intake@acsmedical.com

Last update 03/01/2023