Advanced Care Solutions

PH# 877-748-1977 FAX# 877-748-1985

DIABETIC SUPPLIES ORDER FORM

Patient Name:____DOB:____________

Shipping Address: ____

Start Date: _____________ **Length of need : (X) 12 Months ( ) Other_____ /Months**

Primary Insurance:______________________________________ INSURANCE ID #: ______________________________

Is the patient treated with insulin? ( ) Yes ( ) No **Testing Frequency**:

Prescribed BGM

True Metrix (non talking) **True Metrix Prodigy (talking)** **EasyMax (non talking)** **EasyMax V (talking)**

To Qualify for Talking Meters patients must meet medical necessity supported in Medical Records and with Diagnosis such as ex Legally Blind ect.

Diabetic Supplies Ordered

( ) Test Strips ( ) Lancets ( ) Control Solution 1 PER 3 MONTHS ( ) Lancing Device 1 PER 6 MONTHS ( ) Batter(ies) 1 PKG PER 6 MONTHS
( ) Glucose Monitor 1 PER 5 YEARS

Medicare allows for 1x day or less for non-insulin treated or 3x/day or less for insulin treated testing :

If patient's testing freq. exceeds Medicare guidelines please complete the following and fax the supportive documentation

1. Has the patient been seen in the last six months? ____Y ____N
2. I have documented in the patient's medical record the times testing and the reason (s) for high testing as:
   a. ____Fluctuating Blood Sugar c. _____Hypertension Other:___________________________
   b. ____ Hypoglycemia d. ____ Uncontrolled Blood Sugar

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 t h e patient's medical record and made available to Medicaid or other Insurance for post payment review or audits.

Phys Name (printed): ____________________________________NPI#:_____________________Phone: ______________________

PHYSICIAN/ PRESCRIBER 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 include Diagnosis codes and A1C) with in last 6 months
  - If talking meter is selected please include additional records that justify need with diagnosis

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