Advanced Care Solutions
PH# 877-748-1977 FAX# 877-748-1985

HUMANA/DEVOTED INSURANCE

DIABETIC SUPPLIES PRESCRIPTION FORM

Patient Name:_____DOB:_____

Shipping Address: _____ Phone#:_____

City:_____State_____ Zip Code:_____

Primary Insurance:_____ INSURANCE ID #:_____

GLUCOSE METER SELECTION

- ☐**TRUEresult®**
- **Strip Release Button , 4 Testing Reminder Alarms**
- **Audible Fill Detection**

- ☐ **Prodigy Autocode®**
- Tiny Blood Sample
- Talking Meter
- Alternate Site Testing

******PLEASE NOTE PRODIGY METERS ARE FOR LEGALLY BLIND PATIENTS ONLY AND MUST BE REFLECTED IN DX *******

PHYSICIAN SECTION (REQUIRED) PLEASE FILL OUT COMPLETELY IN ORDER TO AVOID DELAY IN ORDER PROCESSING

- **Is the patient treated with insulin?** ( )Yes ( ) No
- **Diagnosis Code:** ( )E11.9 ( )E10.9 ( )E11.65 ( )E10.65 ( ) H54.8 Other ICD-10 Code:_____
- **Testing Frequency**: ( ) 1x/day ( )2x/day ( ) 3x/day ( ) 4x/day ( ) Other_____

Estimated number of strips & lancets provided for a 90 day period: 1x/day=100 2x/day=200 3x/day=300 4x/day=400 5x/day=450

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 supporting documents

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

Diabetic Supplies Ordered

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

- **Length of need :** ( ) 3months ( ) 6 months ( ) 12 months **Start date:** ____/____/____

Physician Name (printed):_____NPI#:_____Phone:_____

My signature below denotes to the best of my knowledge the patient/caregiver is capable of using the test results for controlling diabetes and is able to use the ordered items which are design for the home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of the monitor and supplies

PHYSICIAN/ PRESCRIBER SIGNATURE _____ DATE _____