



Physician's Order for Continuous Glucose Monitoring, Insulin Pump, and Diabetic Supplies

By my signature below, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient sub prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. For Medicare, Medicaid, or other insurance re			Length of Need:			
DOB:II Cell #: Address: Address: Address: City: State: Zip: City: State: Zip: Phone: Fax: Email:	PATIENT INFORMATION	<u>.</u>	PHYSICIAN INFORM	MATION: NPI:		
Address: City: State: Zip: City: State: Zip: City: State: Zip: Phone: Fax: Email: Member ID #: Group Plan #: Email: Email: Diagnosis ICD-10: E10.65 E10.9 Other E11.9	Patient Name:		Physician Name:			
City:State:Zip:City:State:Zip:	DOB:// C	ell #:	Facility Name:			
Patient's Insurance Plan Name: Phone:	Address:		Address:			
Member ID #:	City: State	e:Zip:	City:	State:	_Zip:	
Diagnosis ICD-10: E10.65	Patient's Insurance Plan Na	me:	Phone:	Fax:		
Diagnosis ICD-10: E10.65			Email:			
E10.9	Member ID #:	_ Group Plan #:				
Patient currently using insulin? YES NO Administration frequency:times per day	2.ag	Date patient	last seen: A1C:			
OR Patient on insulin pump? YES NO Patient is motivated and knowledgeable to us Currently on CGM therapy? YES NO CGM or Insulin Pump, and adheres to a diable treatment plan? YES NO Continous Glucose Monitoring (CGM) Supplies: Non-adjunctive Receiver per month Non-adjunctive Transmitter per month Non-adjunctive Sensors per month Dexcom sensors: changed every 10 days Libre sensors: changed every 14 days Please indicate brand preference: Other Supplies Required: By my signature below, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this prescribed transment regimen that I have prescribed redicate, For Medicare, Medicard, or for his patient sans or rescribed products) listed always patients are rescribed received. For Medicare, Medicari, or other insurance or rescribed products) listed always prediction in some that I have prescribed redicated; listed always prediction in some that I have prescribed redicated; listed always prediction in some transmitter on that I have prescribed redicated; listed always prediction in some transmitter or the medical records for this patient sans or the patient care for the patient care for the resurrance for the resurrance for the patient care for the patient care for the resurrance for the patient care for the patient care for the patient care for the resurrance for the patient care for the resurrance for the patient care for the patient care for the resurrance for the resurrance for the patient care for the patient care for the resurrance for the patient care for the patient care for the resurrance for the patient care for the patient c	Other	E11.9/	_ / Fasting Hy	perglycemia mg/	dL:	
Patient on insulin pump? YES NO High mg/dL: Testing frequency: times per day Currently on CGM therapy? YES NO Date first CGM received (optional): TES NO CGM or Insulin Pump, and adheres to a diable treatment plan? YES NO Continous Glucose Monitoring (CGM) Supplies: Non-adjunctive Receiver per month Non-adjunctive Transmitter per month Non-adjunctive Sensors per month Dexcom sensors: changed every 10 days Libre sensors: changed every 10 days Libre sensors: changed every 14 days		sulin? YES NO			-	
Currently on CGM therapy? YES NO Date first CGM received (optional): treatment plan? YES NO Continous Glucose Monitoring (CGM) Supplies: Non-adjunctive Receiver per month Non-adjunctive Transmitter per month Non-adjunctive Sensors per month Dexcom sensors: changed every 10 days Libre sensors: changed every 14 days Please indicate brand preference: Other Supplies Required: HCPC Code Description Freq. of Use QTY/ By my signature below, I confirm that the patient has the medical condition(s) and the treatment regimen that I have prescribed. The medical roontained on this portest had prescribed treatment plan? YES NO CGM or Insulin Pump, and adheres to a diabet treatment regimen that I have prescribed. The medical roontained on this portest sub to use the prescribed freatment plan? YES NO Insulin Pump & Supplies: Insulin pump / Omnipod PDM E0784 per lnfusion set, non-needle A4230 per lnfusion set, non-needle A4231 per Omnipod pods A4231 per lnfusion set, needle type A4231 per lnfusion set, needle type A4231 per Omnipod pods A9274 per		YES NO	Fluctuation of BG level:			
Non-adjunctive Receiver per month Insulin pump / Omnipod PDME0784 per		1	•		NO	
Non-adjunctive Transmitterper month Non-adjunctive Sensorsper month Dexcom sensors: changed every 10 days Libre sensors: changed every 14 days Omnipod pods A9274per Please indicate brand preference: Other Supplies Required: Description Freq. of Use QTY/		• • • • • •				
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Date: / Physician Signature:	Non-adjunctive Sensors Dexcom sensors: changed Libre sensors: changed Please indicate brand pre Other Supplies Required: HCPC Code y my signature below, I confirm that order accurately reflects the patient's rescribed treatment plan. The patient	per month ged every 10 days levery 14 days eference: Descri the patient has the medical condition is medical condition(s) and the treatment/caregiver is able to use the prescri	Infusion set, needle typ Omnipod pods ption prion prion prion prion(s) listed and is being treated by nent regimen that I have prescribed. Tribed product(s) listed above. For Me	Freq. of Use ne. All the information of the medical records for edicare, Medicaid, or of edicare, Medicaid, or of the medical records for edicare, Medicaid, or other edicare, Medicaid, M	per per	mod