Reliant Medical Supply

DIABETES TESTING SUPPLIES PHYSICIAN ORDER

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **FIVE** ARROWS
CORRECTIONS ON THIS FORM ARE NOT ACCEPTABLE, **IF AN ERROR OCCURS; PLEASE CALL FOR A NEW FORM.**

If not otherwise specified, maximum allowed Duration of Need is 12 months. Duration of Need ____. **15 Refills Maximum.**

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT ADDRESS: _____ **PATIENT PHONE:** _____

PATIENT INSURANCE DETAILS: PRIMARY - _____ SECONDARY - _____

Please check ONE box for EACH of the TWO QUESTIONS below.

INSULIN? ★1a.

Is the patient **TREATED WITH**

☐ **YES** ➔ ____MAX **# OF INJECTIONS** PER DAY **OR** ☐ **ON PUMP**

☐ **NO**

★1b. What is the patient's **DIABETES DIAGNOSIS CODE?**

☐ ICD-10 **E10.9** - **Type 1 diabetes**

☐ ICD-10 **E11.9** - **Type 2 diabetes**

OTHER _____

What is the patient's TESTING FREQUENCY per day; please select ONE BOX only.

I prescribe the following Blood Glucose Testing and Insulin Injection Supplies in the following quantities—

1XD ☐ 100 Blood Glucose Test Strips every 90 days, 100 Lancets every 90 days
2XD ☐ 200 Blood Glucose Test Strips every 90 days, 200 Lancets every 90 days
3XD ☐ 300 Blood Glucose Test Strips every 90 days, 300 Lancets every 90 days
4XD ☐ 400 Blood Glucose Test Strips every 90 days, 400 Lancets every 90 days
5XD ☐ 450 Blood Glucose Test Strips every 90 days, 500 Lancets every 90 days
6XD ☐ 550 Blood Glucose Test Strips every 90 days, 600 Lancets every 90 days
7XD ☐ 650 Blood Glucose Test Strips every 90 days, 700 Lancets every 90 days
8XD ☐ 750 Blood Glucose Test Strips every 90 days, 800 Lancets every 90 days
10XD ☐ 900 Blood Glucose Test Strips every 90 days, 900 Lancets every 90 days
12XD ☐ 1100 Blood Glucose Test Strips every 90 days, 1100 Lancets every 90 days

and 1 Control Solution every **90 days (3 Refills)**, **1** Lancing Device every **180 days (1 Refill)**, **2** Batteries **Annually**, **1** Glucose Monitor **Annually**, Pen needles, Syringes, Sterile Wipes, 100 day supply **(12 Refills) based on injection frequency written above.**

Medicare and other insurances **REQUIRE AN EXPLANATION** for testing more frequently than **1 time per day non-insulin** treated or **3 times per day insulin treated**. **IF APPLICABLE PLEASE COMPLETE BELOW.**

Please Check ALL That Apply!

☐ Fluctuating Blood Sugar ☐ Hypoglycemia ☐ Hyperglycemia ☐ Hypertension
☐ Uncontrolled Blood Sugar ☐ Medication Adjustment ☐ Other _____

Therefore, I confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted the above reason(s) for their high testing frequency.

By my signature below, I confirm that the patient has diabetes and is/was being treated by me. All the information contained on this Physician Order form accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/ caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. For Medicare requirements, I will maintain this signed original document in the patient's medical record file for post-payment purposes. I agree to follow up on the patient every six (6) months while under my care for control of diabetes.

4 Hand Written Signature:

DEA#: _____
NPI #: _____
PHYSICIAN NAME: _____
PHYSICIAN TEL #: (____)_____
PHYSICIAN FAX #: (____)_____
PHYSICIAN ADDRESS:_____
_____

5 Date/Order Start Date:

★★★FAX COMPLETED FORM TO★★★

FAX #: (800)340-2955

OFFICE DIRECT: (702)433-0464

RELIANT MEDICAL SUPPLY

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