DEDICATED MEDICAL PROVIDERS

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Medicare Detailed Written Order

Patient Information:

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Physician Information:

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

ORDER DETAIL:

Order Date: _____ / _____ / _____ <-- Please Fill

☐ FreeStyle Libre 3 Monitor & Sensors	☐ Dexcom G7 Monitor & Sensors
E2103- 1 Reader/1095 Days	E2103- 1 Reader/1095 Days
Length of Need: Lifetime-unless specified otherwise	Length of Need: Lifetime-unless specified otherwise
A4239- 1 Unit/30 Days (1 Unit = 1 month of sensors and supplies)	A4239- 1 Unit/30 Days (1 Unit = 1 month of sensors and supplies)
Length of Need: Lifetime-unless specified otherwise	Length of Need: Lifetime-unless specified otherwise

Diagnosis (ICD10):

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____ <-- Select/Please Fill

Prescribed Number of Glucose Tests Per Day: _____ <-- Please Fill

Current Insulin Regimen:

☐ Insulin Pump ☐ Daily Insulin Injection(s) - Number Per Day: _____ <-- Select/Please Fill

☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan.

☐ A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.

I am the physician primarily responsible for the treatment of this patients diabetes: Yes ☐ No ☐

Patient has had a visit within the last 6 months for treatment of diabetes: Yes ☐ No ☐

Date of Last Visit: _____ / _____ / _____ <-- Please Fill

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____

It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition.

PLEASE INCLUDE PATIENT PROGRESS NOTES