MICHIGAN COMPASSIONATE CARE

28401 Hoover Road Warren MI 48093
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www.mccoffice.net

Continuous Glucose Monitor (CGM) - Detailed Written Order Prior to Delivery

Patient Name _____

Account Number _____ Patient DOB _____ Order Date _____

☑ Face Sheet/Demographics/Chart Notes Attached

- Chart notes must include the need for equipment being ordered and **MUST BE ATTACHED FOR OVER QUANTITY**
- **Date of visit prior to order:** _____

MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:

Reason for Medical Necessity (other than diagnosis): _____

DIAGNOSIS

ICD-10 Code **E11.9 E11.65 E10.9 E10.65** Length of Need in Months **99**

TREATMENT TYPE

Is patient treated with insulin injections and/or insulin pump?	☐ Yes	☐ No
Is patient injecting insulin? How many injections per day? _____ *(Medicare requires 1 or more injections per day to qualify)*	☐ Yes	☐ No
Is patient currently using a Continuous Glucose Monitor (CGM)?	☐ Yes	☐ No

CONTINUOUS GLUCOSE MONITORING BRAND

☑ Preferred Brand: **NONE**

(If left blank, CGM dispensed will be based off insurance guideline)

CONTINUOUS GLUCOSE MONITORING SUPPLIES (Check all for full kit to be sent to patient)

☑ Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor (E2103) 1 per 5-year period.

☑ Supply Allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories.
1-month supply = 1 unit (A4239) **Please provide 3 Units (3 months supply) with 6 refills if insurance allows.**

NOTES

Please note:
-This patient has diabetes mellitus and
-We have concluded that patient has sufficient training/education using continuous glucose monitoring system prescribed and
-Patient is prescribed CGM to improve glycemic control. Patient meets at least one of the following criteria:
A) Patient is insulin treated
B) Patient has a history of problematic hypoglycemia and has documentation of at least one of the following:
i) Recurrent level 2 hypoglycemia that persisted despite multiple attempts to adjust medications
ii) History of 1 level 3 hypoglycemia characterized by altered mental status/physical state requiring third-party assistance for treatment of hypoglycemia.

-Patient has face-to-face visit with the last 6 months.

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials **MUHAMMAD VASIQ M.D.** NPI No. **1750357836**

Telephone No. **586-754-3830** Fax No. **586-754-3840**

Signature _____ Signature Date _____

(Stamped Signature Not Accepted)