

DOCTOR'S ORDER

Diabetic Testing Supplies

Duration of Need:
 Lifetime Yes No

Physician Name:		
Address:		
City:	St:	Zip:

Patient Name:	
Address:	
SS:	DOB:

Order Date: ___/___/___

1. Patient is attempting to control their form of diabetes with insulin injections? Yes No

2. Diagnosis Code:

3. Patient's testing frequency per day:

3a. Medicare requires an explanation for testing more frequently than: 1x day non-insulin treated or 3x day insulin treated (complete if required). The additional testing is needed because the patient has documented episodes of:

Widely fluctuating blood sugars Recurring Insulin Reactions Ketoacidosis
 Other, (explain) _____

4. I prescribe use of the following Diabetic Supplies, and have crossed out the items I am not prescribing:

Glucose Monitor Qty: <input style="width: 40px;" type="text"/>	Lancing Device Qty: <input style="width: 40px;" type="text"/>	Alcohol Swabs Qty: <input style="width: 40px;" type="text"/>
Strips Qty: <input style="width: 40px;" type="text"/>	Control Solution Qty: <input style="width: 40px;" type="text"/>	Insulin Qty: <input style="width: 40px;" type="text"/>
Lancets Qty: <input style="width: 40px;" type="text"/>	Battery Qty: <input style="width: 40px;" type="text"/>	Syringes Qty: <input style="width: 40px;" type="text"/>

5. I confirm the patient/caregiver has successfully completed training or is scheduled to begin training in the use of the items prescribed and the patient/caregiver is capable of using the test results to assure the patient's appropriate glycemic control.

By my signature below, I am stating that: The patient has diabetes and is/was being treated by me. All the information contained on this Doctor's Order Form accurately reflects the patient's the patient diabetic condition and treatment regimen I prescribed. I have seen this patient within the last six (6) months to evaluate their diabetes control and that this document confirms my order. The glucose monitor prescribed is for home use. My medical records for this patient substantiate the prescribed testing frequency. I will maintain a copy of this signed original Doctor's Order in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

INSTRUCTIONS: Please make any necessary changes to reflect the current regimen prescribed for your patient, initial any changes, and sign below to confirm this ongoing course of treatment.

Physician Signature: Date:

Ten Digit NPI #:

Physician Phone: () -
 Fax: () -

Toll Free Fax: **1-888-272-3988**
 Toll Free Phone: **1-800-575-2345**

