CGM & PUMP SUPPLIES CMN

directDiabetes

Please attach CHART NOTES supporting diabetes diagnosis and medical necessity, recent face-to-face/telehealth visit, patient training & hypoglycemia history (if applicable).

Fax: 480-998-5247 - Phone: 480-998-5551 - Email: Service@DirectDiabetes.com

PATIENT INFORMATION: **Patient Account #:** _____

Patient Name: _____ **Date of Birth:** _____

Gender: ☐ M ☐ F **Phone:** _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ **Primary ID:** _____

Secondary Insurance: _____ **Secondary ID:** _____

Date of Last Face to Face: _____

Primary Diagnosis: ☐ E10.9 ☐ E10.65 ☐ E11.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Secondary Diagnosis: ☐ Z79.4 ☐ Other: _____

Documented Reason for Prescribing Supplies - PLEASE ATTACH MEDICAL RECORDS:

☐ Insulin-treated ☐ History of problematic hypoglycemia (Level 3/Level 2) ☐ Insulin pump in use

**Level 3 glycemic event (<54 mg/dl) that substantially altered the mental or physical state enough to require third party assistance.

**Level 2 glycemic event (<54 mg/dl) despite multiple attempts to adjust medication or modify the treatment plan.

SUPPLIES:

☐ A9276 (365 Units - 1 Unit = 1 Day) / A4239 (12 Units - 1 Unit = 1 month) - Sensors - Brand: _____

☐ A9277 (2 Units - 1 Unit = 6 Month) - Transmitter - Brand: _____

☐ A9278 (1 Unit) / E2103 (1 Unit) - Receiver - Brand: _____

☐ A4230 / A4221 / A4224 - Infusion Set - Qty: ☐ 90 ☐ 50 ☐ 40 ☐ 30 - Brand: _____

☐ A4225 / K0552 - Cartridge/Reservoir Set - Qty: ☐ 90 ☐ 50 ☐ 40 ☐ 30 - Brand: _____

☐ A5120 - Protective Barrier Wipes ☐ A6257 - Transparent Dressing ☐ A4245 - Alcohol Wipes

PHYSICIAN INFORMATION:

Physician Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Office Contact: _____ **Phone:** _____ **Fax:** _____

I certify that I am the physician identified on this form and that by signing, I acknowledge, as the patient's treating practitioner, that the patient has sufficient training to effectively use the CGM and/or PUMP SUPPLIES as prescribed and that all supplies are intended for an on-label use case.

Signature: _____ **Date:** _____