Physician Order for Blood Glucose Testing

name surname
41 bridge st
1st floor
MILFORD, NJ 08848

PATIENT HAS REQUESTED THESE SUPPLIES

PLEASE FAX BACK TO

** **(999)139-9999** **

Questions?
Call us!!
(888)968-4876
FAX ID: 1304521

PATIENT INFORMATION (ID: 11)	PHYSICIAN INFORMATION
NAME: ANDTEST PATIENT **DOB:** 10/24/1987 **ADDRESS:** 34 BRIDGE STR MILFORD, NJ 08848	**DR:** QWERTY QWERTY (**NPI:** 1234567890) **ADDRESS:** QWERTY aasd QWERTY, PW 22222 **PHONE:** (123)123-1231 **FAX:** (908)505-4834
ORDER DATE: 03/13/2019	

1 **INSULIN TREATED?** ☐ YES ☐ NO

2 **ICD-10 CODE:**

☐ **Type 1 diabetes mellitus w/ hyperglycemia - E10.65**
☐ **Type 2 diabetes mellitus w/ hyperglycemia - E11.65**
☐ **Type 1 diabetes mellitus w/o complications - E10.9**
☐ **Type 2 diabetes mellitus w/o complications - E11.9**
☐ **OTHER (numerical ICD-10)** ___ ___ ___ . ___ ___ ___ ___

3 **LENGTH OF NEED IS:** Lifetime (unless otherwise specified) OR_____ **MONTH(S)**

4 **PATIENT TESTING FREQUENCY:**

☐ **3X/DAY**	☐ **4X/DAY**	☐ **5X/DAY**	☐ **6X/DAY**	☐ **OTHER** _____ **X/DAY**
300 Strips 300 Lancets	400 Strips 400 Lancets	450 Strips 500 Lancets	550 Strips 600 Lancets	

Supplies Prescribed: (please cross out items you are not prescribing)

Blood Glucose Meter (E0607) - 5 yr.
Test Strips (A4253) - 3 mo.
Control Solution (A4256) - 3 mo.
Replacement Batteries (A4235/A4233) - 6 mo.
Lancet Device (A4258) - 6 mo.
Lancets (A4259) - 3 mo.

5 ****MEDICARE REQUIRES A REASON for testing more frequently than 1X/Day for non-insulin treated OR more than 3X/Day for insulin treated.** I confirm that I have seen this patient within the last six(6) months to evaluate their diabetes control and have identified the reasons for high frequency testing below. ***Please ensure this reason is denoted in your patient's medical records.***

☐ Uncontrolled blood sugar
☐ Hypoglycemia
☐ Hypertension
☐ Fluctuating blood sugar
☐ Hyperglycemia
☐ Obesity
☐ Other (please specify): _____

Please document testing frequency and reason for testing in medical records.

6 **CERTIFICATE FOR VISION IMPAIRED PATIENTS - For E2100 (Speaking Meter)**

1) Patient's best corrected visual acuity: a)_____/_____ or b) ☐ 20/200 or worse
2) Physician's narrative statement supporting medical necessity for a speaking meter (E2100):

FAX ID: 1304521

_____

7 **PHYSICIAN SIGNATURE:** _____ **DATE:** _____/_____/_____

QWERTY QWERTY

NPI # (for Validation): _____

PLEASE SEND MEDICAL RECORDS

BY SIGNING ABOVE, I agree to obtain the original, signed copy of this document in my medical records and the above mentioned patient has been evaluated by me for this diagnosis within the last 6 months. My medical records substantiate I am treating this patient under a comprehensive care plan for Diabetes Mellitus and the patient is able to use the items herein ordered to manage his/her glycemic control. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

Nothing herein is intended to replace or influence the independent judgment of any licensed prescriber. This is not an advertisement.