REF ID: RX-195975

Lincoln Health Supply
301 E Las Olas Blvd
Fort Lauderdale, FL 33301

CONFIDENTIAL FAX

Return Instructions:

(1) Requested documents submitted by fax *must* include this cover sheet in order to be processed;

(2) Documents may be sent by email to: support@lincolnhealthsupply.com. Please include "*RX-195975*" in the email's subject to ensure prompt review.

DATE: Thursday, November 14, 2024
RE: Jeremy Schaffel Test ()

TO:	Timothy Scurlock, MD	**FROM:**	Lincoln Health Supply
FAX:	8555900410	**FAX:**	+18555900410
PHONE:	3175042597	**PHONE:**	877-760-3332

MESSAGE:

Please review and confirm the information below for Jeremy Schaffel Test's ([DOB]) request for the Dexcom Glucose Monitoring System. Kindly return with this attached coversheet and an up-to-date copy of the patient's medical record showing 1.) their most recent office visit within the last 6 months, and 2.) their current diabetic diagnosis and treatment plan. For questions, please contact us at 877-760-3332.

- DISCLAIMER -

Standard Written Order (SWO)
for Continuous Glucose Monitoring and Supplies

dexcom® One Step Ahead

Instructions

1. Complete all fields on this Standard Written Order.
2. Confirm coverage criteria[1] and medical necessity documentation[2] requirements are met.

Patient Information

Patient Name: Jeremy Schaffel Test Date of Birth: _____

Phone: 8003332227 Email: ashleyk@lincolnhealthsupply.com

Address: 1975 E SUNRISE BLVD STE 808 FORT LAUDERDALE, FL 33304

Primary Insurance: _____ Primary Insurance Member ID: 123456789

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

Diagnosis (ICD-10 code that supports medical necessity)

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other*[2] _____

Select, at least one, of the following documented reasons for prescribing CGM to improve beneficiary's glycemic control

☐ Insulin-treated ☐ History of problematic hypoglycemia

Order Detail

[1,†2]

E2103 - Dexcom Reader	A4239 - Dexcom Sensors
Use per manufacturer guidelines, in accordance with FDA indications for use Duration of need: 99 months - unless specified otherwise:	Change Sensor every **10 days** **Dispense up to 90 day supply** Duration of need: 99 months - unless specified otherwise:

DISPENSE AS WRITTEN

Physician Information

Physician Name: Timothy Scurlock MD Phone: 3175042597

NPI: 11111111 Fax: 8555900410

Address: 1114 Newman St, Indianapolis, IN 46201

Office Contact: _____ Notes: _____

I certify that I am the physician identified in the "Physician Information" section below 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: _____