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| --- |
| **Advanced Medical Supply** |
| **Phone: 866-994-2583** |
| **Fax 1st: 469-501-9073**  **Fax 2nd: 817-780-0212** |

**FAX**

**To:**

**Name: {{pcp\_name}}**

**Fax Number: {{pcp\_fax}}**

**From: (no # pages: 3)**

**Name: Advanced Diabetic Supply**

**Fax Number: (469) 501-9073**

|  |
| --- |
| **Subject: {{name}}** |

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| **Message:**  **Please sign the prescription and return the fax along with the recent visit notes or the progress notes of the patient.**  **Thanks** |



**Phone: (866) 994-2583**

**Fax: (817) 780-0212**

**TO: {{pcp\_name}}**

**Address: {{pcp\_address}}, {{pcp\_city}}, {{pcp\_state}} {{pcp\_zip}}**

**Telephone**

**Number: {{pcp\_phone}}**

**Fax**

**Number:**

**{{pcp\_fax}}**

**Date: \_ {{date}}**

**Number of Pages Including Cover:** 2

**Subject:** Continuous Glucose Monitor

**To Whom It May Concern:**

Your Patient has requested prescription for Painless Freestyle Libre device for monitoring glucose for diabetes. Your patient has said the chief complaint is having to prick their fingers so many times a day.

# PLEASE INCLUDE RECENT MEDICAL NOTES AND FACE SHEET

**Confidentiality Notice: Confidential Health Information Enclosed**

Protected Health Information (PHI) is personal and sensitive information related to a person’s health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is **Strictly Prohibited**. If you have received this message by error, please notify the sender immediately to arrange for return or destruction of these documents.

Medicare Standard Written Order



Instructions

1. Complete all fields on this Standard Written Order.

2. Submit this order and the patient’s most recent medical records that demonstrate medical necessity to a DME supplier that provides the FreeStyle Libre 2 system.

Patient Information

Patient Name**: {{name}}** Date of Birth: **{{dob}}**

Phone: **{{phone}}**

Address: **{{address}}**

Primary Insurance: {{insurance}}

Secondary Insurance:

Email:

City**: {{city}}** State**: {{state}}** ZIP**: {{zip}}**

Primary Insurance Member ID: **{{medicare}}**

Secondary Insurance Member ID:

Notes:

Physician Information

Physician Name: **{{pcp\_name}}** Phone: {{pcp\_phone}}

NPI: {{pcp\_npi}}

Address: {{pcp\_address}}

Fax: {{pcp\_fax}}

City: {{pcp\_city}} State: {{pcp\_state}} ZIP:{{pcp\_zip}}

Order Detail

Order Date: **{{date}}**

|  |  |
| --- | --- |
| E2103 (FreeStyle Libre 2 Reader)\* | A4239 (FreeStyle Libre 2 Sensors)\* |
| 1 Reader | 1 Unit/30 Days or 3 Units/90 Days†  (1 Unit = 1 month of sensor and supplies)  - Sensor site changes per manufacturer guidelines  Length of Need: Lifetime-unless specified otherwise: |

Diagnosis (ICD10):

E10.9 E11.65 E10.65 E11.8 E11.9 Other:

Prescribed Number of Glucose Tests per Day: 4\_\_

Current Insulin Regiment:

Insulin Pump Multiple Daily Injections-Number Per Day:  **3** Other:

I certify that I am the physician identified in the “Physician Information” section above 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