edgepark™
Medical Supplies
Since 1928

1810 Summit Commerce Park
Twinsburg, OH 44087

The leading distributor of Ostomy, Wound Care, Urological, Diabetes,
Insulin Infusion and related medical supplies to patients' homes throughout the U.S.

LAKE COUNTY PHYSICIANS'

TO: Sam Ruckman	
FROM:	DEPARTMENT: Edgepark Medical Supplies
FAX NUMBER: **614-652-7292**	PHONE NUMBER: 800.321.0591
DATE:	NUMBER OF PAGES (INCLUDING COVER): 2

1810 Summit Commerce Park
Twinsburg, OH 44087
p 1-855-450-2505 **f** 330-963-6172
w www.edgepark.com

Physician's Written Order

Glucometer and Diabetes Testing Supplies

edgepark Medical Supplies

Start Date ____/____/____

All fields are required to process an order.

patient

First: _____ **Last** _____ **MI** _____ **Patient DOB:** ____/____/____ **Gender** ☐ M ☐ F

Address: _____ **Phone #:** _____

City: _____ **State:** ____ **ZIP:** _____ **E-mail Address:** _____

doctor

Physician Name _____

NPI # _____

Address: _____

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

Phone: _____ **Fax:** _____

insurance

Primary Insurance: LAKE COUNTY PHYSICIANS' ASSOCIATION

Policy/ID #: _____

Group #: _____

Phone #: _____

Secondary Insurance: _____

Policy/ID #: _____

Group #: _____

Phone #: _____

diagnosis

Type 1 Diabetes

- ☐ E10.9 No Complications
- ☐ E10.8 With Complications (unspecified)
- ☐ E10.65 With Hyperglycemia (uncontrolled)
- ☐ E10.649 Hypoglycemia Without Coma

Type 2 Diabetes

- ☐ E11.9 No Complications
- ☐ E11.8 With Complications (unspecified)
- ☐ E11.65 With Hyperglycemia (uncontrolled)
- ☐ E11.649 Hypoglycemia Without Coma

☐ Other: _____

Gestational Diabetes

- ☐ 024.414 Insulin-Controlled
- ☐ 024.410 Diet-Controlled
- ☐ 099.810 Abnormal Glucose (tolerance)

EDD_____ / _____/_____

☐ Other _____

Quantity to dispense of strips, lancets and alcohol wipes per 90 days. (Based on patient's frequency of use/times testing per day.)**

- ☐ 1x/day – 100
- ☐ 2x/day – 200
- ☐ 3x/day – 300
- ☐ 4x/day – 400
- ☐ 5x/day – 450

Times Testing: _____x Testing Per Day

Is the patient currently being treated with daily insulin injections?

☐ No ☐ Yes _____ X Injecting Per Day

Is the patient currently on insulin pump therapy?

☐ No ☐ Yes

Estimated duration of need: _____ **months** (99 = Lifetime)

Has the patient been seen and had his or her diabetes evaluated in the last six months?

☐ No ☐ Yes

Medicare Exceeded Limit Guidelines:

If patient's testing exceeds Medicare guidelines (greater than 1x/day non-insulin-treated or 3x/day insulin-treated testing), **please complete the following:**

I have documented in the patient's medical record the times testing and the reason(s) for high testing as:

- ☐ Fluctuating Blood Sugar
- ☐ Poor Glycemic Control
- ☐ Other _____

products

Dispense the Following Supplies (per 90 days):	**Frequency of Use**
☐ Blood Glucose Monitor (E0607) qty 1 Preferred Meter _____	_____
☐ Syringes (A4206 or S8490)* Size: _____ Gauge: _____ cc: _____ (1 unit per injection)	_____
☐ Pen Needles (A4215)* Size: _____ Gauge: _____ (1 unit per injection)	_____
*Times Injecting Daily _____	
☐ Replacement Battery for Monitor (A4233 or A4235) – qty. 2	_____
☐ Lancing Device (A4258) – qty. 1/180 days	_____
☐ Ketone Strips – qty. 90/90 days ☐ Urine (A4250) ☐ Blood (A4252)	_____
☐ Control Solution (A4256) qty_____	_____
☐ Lancets (A4259)**	_____
☐ Test Strips (A4253)**	_____
☐ Alcohol Wipes (A4425)**	_____
☐ Other _____	_____

**Quantity to dispense based on patient's times testing daily _____

insulin therapy

	Quantity to be Dispensed	**Frequency of Change**
Indicate Insulin Pump Type: _____	_____	_____
1. ☐ Infusion Sets (Type): _____	_____	_____
2. ☐ Reservoirs/Cartridges (Size): _____	_____	_____
3. ☐ PODs _____	_____	_____
Continuous Glucose Monitor Type: _____	_____	_____
☐ Transmitter	1	180 days
☐ Receiver	1	365 days
☐ Sensors 3 boxes = 84 day supply	3	84 days

I certify that I am the physician/practitioner identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature: _____ **Date:** ____/____/____

(Stamps are not acceptable)

Printed Name: _____

Version #: 120115/DIA