DIABETES PATIENT REFERRAL FORM

DATE: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Physician's Name: _____ Phone: _____ Fax:_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy Number: _____

Secondary Insurance Carrier: _____ Policy Number: _____

DIAGNOSIS

☐ **E10.9**	☐ **E11.65**	☐ **Other:_____**
☐ **E11.9**	☐ **E10.65**	

DOCTOR'S ORDERS

Testing times_____ per day
Is the patient insulin dependent? ☐ Yes ☐ No if yes, injects ____ per day
No. of refills _____, _____ Month/Day Supply
****Has the patient (or the patient's caregiver) successfully completed training, or are they scheduled to begin training in the use of the monitor, test strips, and lancet device? ☐ Yes ☐ No**

EQUIPMENT or SUPPLIES

SUPPLIES	GLUCOMETER
☐ **Test Strips** ☐ **Lancets** ☐ **Lancing Device** ☐ **Pen-needles** ☐ **Syringes** ☐ **Batteries** ☐ **Control Solution** ☐ **Other:_____**	☐ **Accu- Check** ☐ **Accu- Check Aviva** ☐ **Prodigy** ☐ **Contour** ☐ **Contour Next** ☐ **TrueMetrix** ☐ **One Touch** ☐ **_____ Meter Provided at physician's office**

******REQUIRED INFORMATION******

THE PAYER WILL REIMBURSE FOR TESTING 1 X PER DAY, NON-INSULIN DEPENDENT OR 3 X PER DAY INSULIN DEPENDENT. IF ORDERING FOR ADDITIONAL TESTING, PLEASE COMPLETE THE FOLLOWING
Has the patient been seen in the last 6 months regarding their diabetes? ☐ Yes ☐ No
Is there documentation with the patient's chart to support additional testing? ☐ Yes ☐ No
Does the patient require a Diabetes Education Class? ☐ Yes ☐ No

_____ _____ _____ NPI_____
Physician Signature Date