



Diabetic Supplies, Inc.
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DIABETES SUPPLIES ORDER FORM – STATEMENT/CERTIFICATE OF MEDICAL NECESSITY

PATIENT DEMOGRAPHICS

Patient Name:	DOB:	Primary Phone:
Address: 841 UNDERWOOD AVE S	Apt. #	City/State/Zip:
Alt Contact/Relationship:	Alt Phone #:	
Primary Insurance:	ID#:	Group#:
Secondary Insurance:	ID#:	Group#:
Subscriber Name:	Relationship	Subs DOB:
Primary Care Physician:	Phone#:	Fax#:

PRESCRIBER ORDERS / STATEMENT OF MEDICAL NEED

Length of Need <input type="checkbox"/> Lifetime <input type="checkbox"/> Other	Last Office Visit:
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ICD-10 DIAGNOSIS

ICD-10 CODE:	Most Recent A1C and Date _____ % _____	Is Patient Insulin Dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes (Insulin Pump) <input type="checkbox"/> Yes, injections _____ x per day
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Pump and Pump Supplies

<input type="checkbox"/> Tandem <input type="checkbox"/> Medtronic <input type="checkbox"/> Omni Pod	<input type="checkbox"/> E0784 Insulin Pump <input type="checkbox"/> New <input type="checkbox"/> Replacement – out of warranty _____	Change Frequency – Cartridge and Infusion Set / Pod A4222, A4225, A4230, A4224, Pod A9274 <input type="checkbox"/> Every 3 days <input type="checkbox"/> Every 2.25 days <input type="checkbox"/> Every 2 days <input type="checkbox"/> Every 1 day
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CGM (Continuous Glucose Monitor) Supplies

<input type="checkbox"/> Dexcom <input type="checkbox"/> Medtronic <input type="checkbox"/> Abbott Libre	<input type="checkbox"/> Reader A9278/E2103	<input type="checkbox"/> Transmitter 4/YEAR A9277	<input type="checkbox"/> Sensors 365/YEAR A9276/A4239
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PHYSICIAN INFORMATION

[UNABLE TO FILL PATIENTS ORDER WITHOUT PHYSICIANS SIGNATURE AND DATE]

Physician Printed Name:	NPI#:
➔ Physician Signature:	Date:

THANK YOU FOR CHOOSING DIABETIC SUPPLIES, INC.

Please attach Supporting Documentation and Clinical Notes and Fax to 614-481-9849