

# CGM Order Form

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Remove portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

- K0554 – Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitoring system – 1 unit
- K0553 – Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories. – 6 units (1 unit of service = 1 months supply)

Brand of CGM ordered \_\_\_\_\_

PATIENT INFORMATION					
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address				city	State ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email		Alt Contact Phone
PRESCRIBER INFORMATION					
Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone		Office Fax	
Practice / Facility Name		Prescriber Name / Specialty			
Address			City	State	ZIP
Prescriber State License #	DEA #	NPI #		Medicaid UPIN #	
INSURANCE INFORMATION					
Insurance Provider		Insured's Name		Relationship to Patient	
Plan ID #	BIN#	PCN#		RX Group#	
Eligible For Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare #		Prescription Card <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List Carrier			
*Please Include a Copy of the Front and Back of Insurance Card*					
STATEMENT OF MEDICAL NECESSITY- Please include Applicable Clinic Chart Note					
Diagnosis Code _____ A1C _____ Number of Injections per day _____					
Currently on CGM - <input type="checkbox"/> Yes <input type="checkbox"/> No			Currently on Insulin Pump - <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> The patient's insulin treatment requires frequent adjustment on the basis of BGM or CGM testing results.					
<input type="checkbox"/> Patient has received or has scheduled diabetes education specific to CGM usage and/or received ongoing instruction specific to CGM usage and ongoing adherence to usage of CGM.					
<input type="checkbox"/> Patient or caregiver can hear and view alerts and respond accordingly.					
<input type="checkbox"/> Patient has otherwise qualifying circumstances or is deemed otherwise medically necessary due to _____					

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please send the completed form and recent chart notes.**

Note: The information Contain in This Document Will become a Legal Prescription Is to Comply with his/her State Specific Pharmacy and Medical Board Guideline Such As e-prescribing, State Specific Prescription Form, Fax Language, Number of Prescription Allowed on a Single Prescription Form etc. If more than one page is required, make additional copies. Non-Compliance with state specific requirement could result in outreach to the Prescriber.

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