CGM Order Form

PHONE 303-822-9440 | FAX 833-479-0707

EMAIL ID dme@byerspharmacy.com

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 ☐ M ☐ F	Last 4 SSN	Primary Language	
Address				city	State	ZIP
Email	Home Phone		Work Phone		Cell Phone	
Primary Contact f'1ethod {check one} ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ 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) ☐ Email ☐ Phone ☐ 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 ☐ Yes ☐ No If yes. list Medicare #		Prescription Card ☐ Yes ☐ 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 - ☐ Yes ☐ No Currently on Insulin Pump - ☐ Yes ☐ No

☐ The patient's insulin treatment requires frequent adjustment on the basis of BGM or CGM testing results.

☐ 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.

☐ Patient or caregiver can hear and view alerts and respond accordingly.

☐ 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.