CONTINUOUS GLUCOSE MONITORING (CGM) STANDARD WRITTEN ORDER

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone:_______________________**Ins ID#:**_______________

Patient DOB:____________________ **Sex:** ______**(M/F)**

Refer to Continuous Glucose Monitoring (CGM) coverage criteria sheet for all required documentation.

CONTINUOUS GLUCOSE MONITOR

Diagnosis and Code:

E10.9 Type 1 Diabetes Mellitus without Complications

E11.65 Type 2 Diabetes Mellitus with Hyperglycemia

E11.8 Type 2 Diabetes Mellitus with Unspecified Complications

E11.9 Type 2 Diabetes Mellitus without Complications

Other: ____

Date of Last Visit: ____________ Length of Need (of months)___________1-99 (99= lifetime)

☐ Continuous Glucose Monitor/Receiver

☐ Sensor - 1 Unit every 30 days (A4239) or 1/day (A9276) *(1 Unit = 1 month)*

Transmitter - 1 every 3 months

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided,

Provider's Signature: ____ Date: ___________NPI: _______________

Provider's Name: ____ Telephone: ___________________________