CONTINUOUS GLUCOSE MONITORING (CGM) **STANDARD** WRITTEN ORDER

PROCARE HOME MEDICAL

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 ☐ E11.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Order Date: _____ 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

Current Insulin Regimen: ☐ Insulin Pump ☐ Multiple Daily Injections - # Per Day: _____ ☐ Other: _____

MEDICAL NECESSITY INFORMATION: *Must also be supported in the medical records, if applicable*

1. Does the patient have diabetes mellitus? ☐ Y ☐ N
2. Is the patient insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump? ☐ Y ☐ N
3. Is the patient's insulin treatment regimen requires frequent adjustment by the patient on the basis of BGM or CMG testing results? ☐ Y ☐ N
4. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the patient to evaluate their diabetes control and determined that criteria (1-3) above are met ☐ Y ☐ N
5. Every six (6) months following the initial prescription of CGM, the treating practitioner has an in-person visit with the patient to assess adherence to their CGM regimen and diabetes treatment plan ☐ Y ☐ N

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: _____