Physician's Order
DIABETIC SUPPLIES

Patient Information

Name:_____

Address:_____

City, State, Zip:_____

Medicare#:_____ DOB:_____

Phone: _____Height:_____ Weight: _____

PROFESSIONAL. MEDICAL HOMECARE
4869-C MEMORIAL DRIVE
STONE MOUNTAIN, GA 30083
Phone: 404-292-9190
Fax: 404-508-9225
NPI Number: XX2287131

Diagnosis	Description
_____	_____
_____	_____

Length of Need[ ]_____ Months[ ]Lifetime_____

Please answer the following questions.

Yes No 1.) Do you treat this patient for diabetes?

Yes No 2.) Is the patient able to safely use the diabetic supplies?

_____ 3.) What was the last day you treated this patient for diabetes?

_____ 4.) What is the frequency of blood glucose testing each day?

Yes No 5.) Is the patient or caregiver capable of being trained to use a glucometer?

For a patient who is not currently being treated with insulin injections, up to 1 00 test strips and up to 1 00 lancets or one lens shield cartridge is covered every 3 months.

For a patient who is currently being treated with insulin injections, up to 1 00 test strips and up to 1 00 lancets or one lens shield cart edge is covered every month.

If refills or quantities of supplies exceed utilization guidelines, documentation that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed must be present in the physician's and supplier's records

Based upon the above information, the following items are needed by this patient for the stated length need:

Date	Check Items(s)	Quantity	HCPC	Description
	☐	2.00	A4259	FREESTYLE LANCETS
	☐	2.00	A4253	TEST STRIPS

1, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment from this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and are available upon request.

_____ _____

Physician's Signature: Date:

Physician Name:_____ NPI Number:_____

Address:_____ Phone Number:_____

City, State, Zip:_____ Fax Number:_____