DIABETES SUPPLY ORDER FORM

for Medicare Patients

HCD0313

FAX completed form with Physician's Signature to (888)565-4411 (toll-free fax)

1. Patient Information:

Name: ______ Phone: (   ) ______ DOB: ___/___/___ (MM DD YY) Gender: M ○ F ○

Address: ______ City: ______ State: ______ Zip: ______

Insurance: ○ Medicare # ______ ○ Other ______

2. Diagnosis: Diabetes Mellitus ICD-9

- ○ 250.01 Type I - w/o complication, not stated as uncontrolled
- ○ 250.03 Type I - w/o complication, uncontrolled
- ○ 250.00 Type II - or unspecified type, w/o complication, not stated as uncontrolled
- ○ 250.02 Type II - or unspecified type, w/o complication, uncontrolled
- ○ Other ______

3. Testing Times/Injection Frequency

Test strips/lancets/syringes prescribed for a 90-day period:

○ 1x/day = 100 ○ 2x/day = 200 ○ 3/day = 300

○ 4x/day = 400 ○ 5x/day = 450 ○ other: ______

- Patient currently using insulin ○ Y ○ N
- Insulin injecting frequency ______ per day

4. Diabetes Testing Supplies Required:

(Select supplies needed)

- ○ Home Blood Glucose Monitor E0607 *(1 every 5 years)*
- ○ Blood Glucose Test Strips A4253 *(see testing frequency above)*
- ○ Lancets A4259 *(see testing frequency above)*
- ○ Syringes A4206 *(see injecting frequency above)*
- ○ Lancing Device A4258 *(1 every 6 months)*
- ○ Control Solution A4256 *(1 every 3 months)*
- ○ Meter Battery A4235 *(2 every 6 months)*
- ○ Voice Synthesized Blood Glucose Monitor E2100 *(1 every 5 years)*

5. Duration of Need:

○ 6 months ○ 12 months ○ lifetime

○ months ______

6. For High Frequency Testers Only: (Required)

Medicare defines high frequency as insulin treated testing more than 3 times per day and non-insulin treated testing more than 1 time per day.

Last saw & evaluated patient's diabetes control on:

___/___/___ (MM DD YY)

7. Physician's Information:

Physician's Name: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Fax: ______

NPI #: ______

License #: ______ Exp Date: ___/___/___ (MM DD YY)

8.

Physician's Signature ______

___/___/___ (MM DD YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

PATIENT COMPLETES: Authorization of Billing / Medical Information Release

I request that payment of my insurance benefits (Medicare, Medicare Supplemental or other) be made to **Home Care Delivered Inc.** for any supplies or services furnished to me by **Home Care Delivered Inc.** I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of medical information about me to release to **Home Care Delivered Inc.** any information needed to determine benefits payable for these supplies or services. In addition, I authorize **Home Care Delivered Inc.** to release my medical records to insurers as well as medical professionals. I authorize **Home Care Delivered Inc.** to contact me by telephone, email or mail regarding my medical supplies.

Patient's Signature ______

___/___/___ (MM DD YY)

If patient has signed by marking an "x" due to language barriers or physical limitations, the signature and address of the witness should be entered next to the beneficiary's mark.

If the patient is unable to sign due to a physical or mental condition, an Authorized Representative of the patient must complete the section below. By signing on behalf of the customer, you acknowledge that you have authority to do so.

Patient Name: (please print) ______

By: Authorized Representative's Signature: ______ *Authorized Representative's Name:* ______

Relationship to Patient: ______ *Physical/Mental Reason patient is unable to sign:* ______

Address: ______ *City:* ______ *State:* ______ *Zip:* ______