Diabetes Testing Supplies Referral with Physician's Order

CCS MEDICAL

Changes to form must be initialed and dated by prescriber

Complete and Fax Toll Free To: 800.824.2320

CCS Medical Rep: _____
Phone Number: _____

PATIENT INFORMATION

1. Patient Name: _____ DOB: _____

Phone: _____ Alt. Phone: _____ Email: _____

Patient Address: _____

Person Authorized on Account: _____ Phone: _____ Relationship to Patient: _____

PATIENT INSURANCE INFORMATION (Complete OR fax a copy of the front and back of the insurance card with this form)

2.

Primary Insurance:
☐ Medicare ☐ Other _____
ID # _____ Group # _____
Phone _____
Policyholder's Name _____

Secondary Insurance (if any):
_____
ID # _____ Group # _____
Phone _____
Policyholder's Name _____

ORDER INFORMATION

3. _____ Order Start Date

4. ☐ Non-Insulin Treated
☐ Insulin Treated — Number of injections per day: _____ OR ☐ Insulin Treated — Pump/Pod Therapy

5. Length of Need: 99 months (lifetime) unless noted _____

6. Diagnosis (ICD-9 and equivalent ICD-10)
☐ 250.00 Type II (E11.9) ☐ 250.02 Type II (E11.65) ☐ 250.01 Type I (E10.9) ☐ 250.03 Type I (E10.65)
Other _____

PRESCRIBED TESTING FREQUENCY AND ITEM(S)

7. Prescribed Testing Frequency (as documented in your patient's medical records)
Strips and Lancets (quantity based on a 90 day supply)
☐ 1x/day = 100 ☐ 2x/day = 200 ☐ 3x/day = 300 ☐ 4x/day = 400 ☐ 5x/day = 500 ☐ 6x/day = 600
☐ 7x/day = 700 ☐ 8x/day = 800 ☐ 9x/day = 900 ☐ 10x/day = 1000 Other: _____
Lancing Device: 1 per 6 months Control Solution: 1 per 3 months Meter Battery: 1 per year

8. Prescribed Diabetes Testing Supplies (cross out items not ordered)
Meter Test Strips Control Solutions Lancets Lancing Device Battery
Alcohol Swabs Pen Needles Ketone Strips Syringes

PRESCRIBER INFORMATION AND SIGNATURE

9. My signature below denotes to the best of my knowledge the patient/caregiver is capable of using the test results for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of the monitor and supplies. I will submit medical records to support this order upon audit request of Medicare or other payor.

▶ Date _____ (Date Stamps NOT Accepted)
▶ Prescriber Signature _____ (Signature Stamps NOT Accepted. Prescriber name & NPI # MUST be printed on form.)

10. Facility Name _____
Address _____
_____
Phone _____
Fax _____

☐ Name _____ NPI#: _____
☐ Name _____ NPI#: _____
☐ Name _____ NPI#: _____
☐ Name _____ NPI#: _____