Theraputic Continuous Glucose Monitor (CGM)

Medicare Detailed Written Order

Please fax to : (855) 244-3350

ACTIVE MEDICAL
120 Prosperous Pl Ste 103
Lexington, Ky 40509
859-421-1195

Instructions

1. Complete all fields on this Detailed Written Order.
2. Use the Noridian November 2017 Physician Resource Letter (Continuous Glucose Monitors) to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier to provide a CGM system.

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

_____

Physician Information

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

Order Detail

Order Date: _____ / _____ / _____

K0554 (Receiver for use with Theraputic CGM)	K0553 (Theraputic CGM, Supplies & Accessories)
1 Reader/1095 Days Length of Need: Lifetime - unless specified otherwise: _____	1 Unit/30 Days (1 Unit = 1 month of sensors and supplies) Length of Need: Lifetime - unless specified otherwise: _____

Diagnosis (ICD10):

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Prescribed Number of Glucose Tests Per Day: _____

Current Insulin Regimen:

☐ Insulin Pump ☐ Multiple Daily Injections - Number Per Day: _____ ☐ Other: _____

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____