PORT CITY MEDICAL

Send completed form, demographics sheet, plus copy of front and back of insurance card(s) to:
Fax: (251) 650 - 4498

Diabetes Supplies Order Form

Referral #

PATIENT INFORMATION:

Patient Name (Last, First):_____ Date of Birth (MM/DD/YY):_____
Street:_____ Start Date:_____
City:_____ State:_____ Zip Code:_____
Phone Number:_____ Mobile Number:_____
Language: ❑ English ❑ Spanish ❑ Other:_____ Email:_____
Primary Insurance Name: _____ Policy #: _____ Group #: _____
Secondary Insurance Name: _____ Policy #: _____ Group #: _____

PROVIDER INFORMATION (please circle one)

Provider First and Last Name, NPI#

Practice Name:_____
Street:_____
City:_____ State:_____ Zip Code:_____
Phone Number:_____
Fax Number:_____
Email:_____

PROVIDER'S ORDERS & ICD-DIAGNOSIS:

ICD-10 Code: ❑ E10.9 Type 1 Diabetes Mellitus Without Complications ❑ E10.65 Type 1 Diabetes Mellitus With Hyperglycemia
❑ E11.9 Type 2 Diabetes Mellitus Without Complications ❑ E11.65 Type 2 Diabetes Mellitus With Hyperglycemia
❑ O99.810 Abnormal Glucose Complicating Pregnancy ❑ H54.0 Blindness, Both Eyes
❑ O24.419 Gestational Diabetes Mellitus in Pregnancy, Unspecified Control ❑ Other:_____

Testing Supplies

Glucose tests per day:_____ Brand of glucose meter:_____ ❑ Send meter & lancing device
❑ All necessary testing supplies (test strips, lancets, control solution, batteries) for a 90 day supply and refills for 1 year
❑ Request a replacement meter kit (ECK) ❑ Request a replacement gestational diabetes meter kit (GCK)

Pump Supplies

Brand of current pump:_____
❑ All necessary pump supplies (reservoirs, infusion sets, batteries and skin prep pads) for 90 days and refills for 1 year
Frequency of infusion sets/reservoirs changes per manufacturer guidelines unless otherwise noted:_____

CGM Supplies

Brand of current CGM:_____
❑ All necessary CGM supplies (sensors, skin prep supplies) for 90 days and refills for one year
❑ 2 Transmitters with refills for one year ❑ If different:_____
Frequency of sensor changes per manufacturer guidelines unless otherwise noted:_____

FOR MANAGED MEDICARE AND/OR MEDICAID PATIENTS ONLY:

Medicare Utilization Guidelines: Medicare allows 1x/day or less for non-insulin treated or 3x/day or less for insulin treated
1. Patient is treated by: ❑ Insulin ❑ Oral ❑ Diet and exercise
2. Has the patient been seen in the last six months? ❑ Yes ❑ No

Licensed Healthcare Provider's Acknowledgement: My signature below denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient has diabetes, is being treated by me and I have seen the patient in the last 6 months. To the best of my knowledge the patient/caregiver has successfully completed training or is scheduled to begin training on the use of the monitor and other prescribed supplies which are designed for home use, and is capable of using the test results to control diabetes. The patient is informed that s/he will be contacted by Port City Medical regarding coverage for items ordered. I authorize the prescription of the supplies above and my signature aligns with the pre-printed name.

Licensed Healthcare Provider's Signature: _____
Date: Signature stamps are NOT acceptable Date stamps are NOT acceptable