PROMED DME

Toll Free: 1-844-693-6316
Fax Order To: 844-972-1531
Email Order To: Neworders@promed-dme.com

CGM Physicians Order Form: Chart Notes Must Accompany The Order and Must Be From Last 6 Mo.

Rep: _____ **Referral Source:** _____

Patient Name: _____ Patient DOB: _____

Patient Phone: _____ Patient Email: _____

Insurance Policy: _____ ID #: _____

DIAGNOSIS

ICD-10 Code: _____ Duration of Need: _____ months
(1-99 months; 99=lifetime)

TREATMENT TYPE

Is patient on an insulin pump?	☐ Yes	☐ No
Is patient on multiple daily injections?	☐ Yes	☐ No
If so, how many injections per day? _____ (Medicare requires 3 or more injections per day to qualify)		
Is the patient on a sliding scale?	☐ Yes	☐ No
Is patient currently using a Continuous Glucose Monitor (CGM)?	☐ Yes	☐ No

CONTINUOUS GLUCOSE MONITORING BRAND

☐	Dexcom	☐	Libre	☐	Libre 2	☐	Other: _____

PRESCRIBING PHYSICIAN INFORMATION

☐	Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor (K0554) 1 every 3 yrs.
☐	Supply Allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories. 1-month supply = 1 unit (K0553)

PRESCRIBING PHYSICIAN INFORMATION

By signing below I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

Name & Credentials _____ NPI _____

Signature _____ Signature Date _____

(Stamped signature not accepted)

Phone _____ Fax _____