

Diabetes Self-Management Education/Training- Certificate of Medical Necessity (Patient Order Form)

Referral from: Provider Name: _____ Fax #: _____

Patient Data: Name: _____

DOB: _____ Social Security#: _____

Address: _____

Primary Phone #: _____ Other Phone#: _____

Insurance Type _____ **(PLEASE INCLUDE COPY OF PATIENT'S INSURANCE CARD)**

____ Please mark if patient has no insurance and is self-pay

RX: Please write current ICD-10 diagnoses here _____ or, select from the list below by marking the line with a "X":

Diagnosis

- ____ E11.8 Type 2 diabetes mellitus with unspecified complications
- ____ E11.9 Type 2 diabetes mellitus without complications
- ____ E10.8 Type 1 diabetes mellitus with unspecified complications
- ____ E10.9 Type 1 diabetes mellitus without complications
- ____ O24.410 GDM in pregnancy, diet controlled
- ____ O24.41 GDM in pregnancy
- ____ O24.01 Pre-existing DM, T1 in pregnancy
- ____ O24.11 Pre-existing DM T2, in pregnancy
- ____ R73.09 Prediabetes (abnormal fasting glucose)
- ____ R73.02 Prediabetes (Impaired glucose tolerance)

SERVICE(S) TO BE PREFORMED please mark appropriate line for service requested with a "X":

- ____ DIABETES SELF-MANAGEMENT TRAINING/SUPPORT (DSMT/S) and MEDICAL NUTRITION THERAPY (MNT)
- ____ GESTATIONAL DIABETES MELLITUS COUNSELING (Group or Individual)
- ____ PREDIABETES EDUCATION
- ____ INSULIN TEACHING/MEDICATION ADMINISTRATION ONLY →
- INSULIN TYPE: _____
- DOSE(S): _____ & TIME(S): _____
- ____ DSMT/S ONLY ____ DIABETES MNT ONLY

Patients with special needs requiring individual DSMT/S

Please mark all that apply:

- ____ Vision ____ Hearing ____ Physical ____ Cognitive Impairment
- ____ Language Limitations
- (Interpreter Needed-specify language needed) _____
- ____ Other: _____

DSMT/S Medicare Requirements: Medicare coverage of DSMT/S and MNT requires providers to provide documentation of a diagnosis of diabetes based on one of the following:

- Fasting blood glucose \geq to 126mg/dL on two different occasions; or
- 2 hour post-glucose challenge \geq to 200mg/dL on 2 different occasions; or
- A random glucose test \geq 200mg/dL for a person with symptoms of uncontrolled diabetes

PLEASE INCLUDE OTHER LABS IF AVAIABLE ON ALL REFERRALS:

A1C _____ BLOOD GLUCOSE _____
 LIPIDS: T-CHOL _____ LDL-C _____
 HDL-C: _____ TRIGLYCERIDES _____
 OGTT(pregnancy): ____ FASTING ____ 1HR ____ 2HR ____ 3HR
 Blood Pressure: _____

Medicare Required Lab Results:

FBG _____ and **FBG** _____ or
2 hr OGTT: _____ and **2 hr OGTT:** _____ or
Random BG \geq with symptoms: Random BG _____
 ____ excessive thirst ____ excessive urination ____ excessive hunger ____ blurry vision
 ____ tiredness ____ unintentional weight loss ____ other: _____

SIGNATURE REQUIRED MD/DO/APRN/PA: _____ DATE: _____

PLEASE FAX COMPLETED FORM TO 859-257-0659