HealthCare
BARNSTABLE BROWN DIABETES CENTER
2195 Harrodsburg Road, Suite 125, Lexington, KY 40504 859-323-2232, option 3

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 EDCUCATION
_____INSULIN TEACHING/MEDICATION ADMINSTRATION 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 ≥ to 126mg/dL on two different occasions; or
- 2 hour post-glucose challenge ≥ to 200mg/dL on 2 different occasions; or
- A random glucose test ≥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 ≥ 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