

Diabetes Supply Order Form

Certificate of Medical Necessity

Date of Service: _____

Patient DOB: _____

Height: _____ Weight: _____ M F

Alt Phone: _____

Insurance Co: _____

Insurance Phone: _____

Or Attach Demographic Info

Patient Name: _____

Insured Phone: _____

Insured Name: _____

Insured Address: _____

City, ST, Zip: _____

Insured SSN: _____

Insured ID No. _____

ICD9 Diagnosis Code: 250.01

Length of Need:

(days, weeks, months) _____ Lifetime

Prognosis: Good

Detailed statement of Medical Need for Home Treatment:

- This patient requires the item(s) for treatment of the condition indicated.
- This condition is chronic in nature, and the item(s) will have a lifetime need.
- If this therapy could not be performed in the home, hospitalization or emergency room visits would be required.

| Prescribed Item(s) | HCPCS Code | Prescribed Item(s) | HCPCS Code |
|---|------------|--|------------|
| <input type="checkbox"/> Infusion Sets | A4230 | <input type="checkbox"/> CGM Sensors Continuous Glucose Monitor | A9276 |
| <input type="checkbox"/> Cartridges | K0552 | <input type="checkbox"/> CGM Transmitter Continuous Glucose Monitor | A9277 |
| <input type="checkbox"/> Dressing/Tape | A6257 | <input type="checkbox"/> CGM Receiver Continuous Glucose Monitor | A9278 |
| <input type="checkbox"/> Batteries | K0604 | <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> Skin Barrier Wipes | A5120 | <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> Adhesive Remover Wipes | A4250 | | |
| <input type="checkbox"/> Ketone Strips | A4250 | | |
| <input type="checkbox"/> Test Strips | A4253 | | |
| <input type="checkbox"/> Lancets | A4259 | | |
| <input type="checkbox"/> OmniPod | A9274 | | |

I certify that the above services are required, are medically necessary and are authorized by me. This patient has been seen by me within this past year and is under my care, and is in need of the services specified herein. This document may serve as a written confirmation of a verbal order, and the information above is contained in the patient's medical record.

Healthcare MD/Practitioner Signature _____

Date: _____

NPI: _____

Lic No: _____

Healthcare Provider Name / Address / Phone

Please Return to:

PH: 800.251.2511 or 919.870.8600

FX: 866.271.2711 or 919.844.2802

Active Healthcare, Inc.

9104 Falls of Neuse Road, Suite 100

Raleigh, NC 27615