Active Healthcare, Inc.™
helping you breathe easy™

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Raleigh, NC 27615
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ACHC ACCREDITED

Diabetes Supply Order Form

Certificate of Medical Necessity

Date of Service: _____

Patient DOB: _____

Or Attach Demographic Info

Patient Name: _____ Height: _____ Weight: _____ ❑ M ❑ F

Insured Phone: _____ Alt Phone**:** _____

Insured Name: _____ Insurance Co: _____

Insured Address: _____ Insurance Phone: _____

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
❑ Infusion Sets	A4230
❑ Cartridges	K0552
❑ Dressing/Tape	A6257
❑ Batteries	K0604
❑ Skin Barrier Wipes	A5120
❑ Adhesive Remover Wipes	A4250
❑ Ketone Strips	A4250
❑ Test Strips	A4253
❑ Lancets	A4259
❑ OmniPod	A9274

Prescribed Item(s)	HCPCS Code
❑ CGM Sensors Continuous Glucose Monitor	A9276
❑ CGM Transmitter Continuous Glucose Monitor	A9277
❑ CGM Receiver Continuous Glucose Monitor	A9278
❑ _____	_____
❑ _____	_____

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

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