

Diabetic Testing Supply Prescription

Referred by:	Medications from Pharmacy: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name:	Birthdate:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	City:	State: MI Zip:
Email:	Cell:	Other Phone:

Insurance:

Meridian Health Plan ID:	HMO Plan:
Medicaid ID:	Policy ID:

Duration of Need:
 12 months Other: _____ (Default is 12 months if nothing is marked.)

Diagnosis Code:

 Type 1 = E10.9 (no complication) E10._____ (list additional numbers to specify complications)

 Type 2 = E11.9 (no complication) E11._____ (list additional numbers to specify complications)

Other: _____ Gestational = _____ Due Date: _____

 Is patient treated with **insulin**? YES NO If yes, are they using an insulin pump? YES NO
Diabetes Testing Supplies: Glucose Monitor: HAS / NEEDS * (circle one) ←

 Test Strips Lancets Alcohol Pads Syringes: _____ vol _____ G _____ mm QTY _____
 Control Solution Other: _____ Pen Needles _____ G _____ mm QTY _____

Recommended Testing Frequency:

<input type="checkbox"/> 1 time/day	= up to 50 test strips/100 lancets/mo	<input type="checkbox"/> 4 times/day	= up to 150 test strips/200 lancets/mo
<input type="checkbox"/> 2 times/day	= up to 100 test strips/100 lancets/mo	<input type="checkbox"/> 5 times/day	= up to 175 test strips/200 lancets/mo
<input type="checkbox"/> 3 times/day	= up to 105 test strips/100 lancets/mo	<input type="checkbox"/> 6 times/day	= up to 200 test strips/200 lancets/mo
		<input type="checkbox"/> Other: _____ times/day	Qty: _____

Please note reason for testing more than 6 times per day: _____

Physician Information:

Physician Name:		
Physician Signature:		Date:
Address:	DEA:	NPI:
City:	Email:	
State: Zip:	Phone:	Fax: