PHYSICIAN'S ORDER CGM & SUPPLIES

Effective Date: ____ / ____ / ____

Representative: Megan Pawlowski (419) 351-4459

TOTAL MEDICAL SUPPLY

(P) 877-670-1120
(F) 567-245-4566 (F) 877-670-1121

Powered by Parachute Health

OFFICE CONTACT

Name: _____ Phone: _____ Email: _____

PATIENT INFORMATION

PATIENT NAME D.O.B.

ADDRESS

CITY STATE ZIP

PHONE ALT. PHONE

PHYSICIAN INFORMATION

PHYSICIAN'S NAME

ADDRESS

CITY STATE ZIP

PHONE FAX

INSURANCE (OR INCLUDE DEMOGRAPHICS)

Primary Insurance Information: ID #:

Secondary Insurance Information: ID #:

CGM SUPPLIES

☒ Continuous Glucose Monitor & CGM Monthly Supply Allowance

BRAND: ☐ Dexcom ☐ Libre

Model per pt preference unless otherwise stated:_____

Diagnosis Code(s):_____

- Pump: ☐ YES ☐ NO
- Insulin: ☐ YES ☐ NO Name:_____ **REQUIRED**
- # OF INJECTIONS: _____
- LAST DIABETES VISIT: ____ / ____ / ____
- Medication List & A1C

DIAGNOSIS MUST BE LISTED IN THE MEDICAL RECORDS

INFUSION PUMP SUPPLIES

☐ Infusion Pump Supplies (cartridge & infusion set)

☐ Every 3 days (30) ☐ Every 2.25 days (40)

☐ Every 2 days (50) ☐ Every 1 day (90)

BRAND/MODEL: Tandem

☐ Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections

☐ Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control -- evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dL

Length of Need: LIFETIME OR _____

Physician please note: No product authorized herein will be supplied without the consent of the patient.

▶ _____ *PHYSICIAN SIGNATURE*

▶ _____ *DATE*

▶ _____ *NPI #*

BY SIGNING ABOVE, I AM STATING THAT I am or was this patient's treating physician during the order period and this is my attestation of medical necessity. The order accurately reflects the patient's condition. I certify that patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this written order. I will maintain an original signed copy of this order in my medical records and make it available to Total Medical Supply, Medicare, their authorized agents or other insurer, if required. By signing above I certify that the patient is being seen every 6 months to ensure adherence to treatment instructions.

PLEASE SEND DEMOGRAPHICS AND OFFICE VISIT NOTES TO 567-245-4566