PHYSICIAN'S ORDER CGM & SUPPLIES

Effective Date: ____ / ____ / ____
Representative:

TOTAL MEDICAL SUPPLY
(P) 877-670-1120
(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
- **Daily insulin injections:** ☐
- **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 _____ **Monthly Refills:** (11) 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.

****ONLY NEEDED IF PATIENT IS IN OFFICE AT TIME OF ORDER:****

ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL RECORDS: By signing this form, I authorize direct payment of insurance benefits by Medicare or my insurance company to Total Medical Supply, Inc. (TMS). In the event that my insurance carrier does not accept assignment of benefits. I understand that payment may be sent directly to me and that I am obligated to endorse and directly send such payment to TMS for payment of my bill. I hereby release to TMS, insurance agents, and representative(s) of accrediting organizations any and all medical records. In order to process insurance claims, I also hereby authorize TMS to furnish medical records to my insurance(s).

_____ Patient (or Patient Caregiver/Representative) Signature

_____ Relationship to Patient

_____ Date

PLEASE SEND DEMOGRAPHICS AND OFFICE VISIT NOTES TO 877-670-1121