PHYSICIAN'S ORDER CGM & SUPPLIES

(P) 877-670-1120
(F) 832-706-4257 (F) 877-670-1121

Powered by Parachute Health

Effective Date: ____ / ____ / ____

Representative: Rafael Cardenas (832) 506-4007

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 832-706-4257