



Phone Number: 423-631-0030

Fax Order To: 423-631-0052

Email Order To: info@medly-health.com

CGM Physicians Order Form: Chart Notes Must Accompany The Order and Must Be From Last 6 Mo.

Please Fax Patient Demographics and Chart Notes along with this Order to prevent any shipping delays.

Rep: Anthony Crist

Facility Name: _____

Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Patient Email: _____

Insurance Policy: _____

Insurance ID#: _____

DIAGNOSIS

ICD-10 Code: _____

Duration of Need: _____ months

(If not otherwise noted, duration = 99 months)

TREATMENT TYPE

Is patient on an insulin pump? Yes No

Is patient on multiple daily injections? Yes No

If so, how many injections per day? _____

(Medicare requires 3 or more injections per day to qualify)

Is patient using a Sliding Scale for at least one injection? Yes No

Is patient currently using a Continuous Glucose Monitor (CGM)? Yes No

CONTINUOUS GLUCOSE MONITORING BRAND

Dexcom

Libre

Libre 2

Other: _____

PRESCRIBING PHYSICIAN INFORMATION

Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor (K0554) 1 every 3 yrs.

Supply Allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories. 1-month supply = 1 unit (K0553)

PRESCRIBING PHYSICIAN INFORMATION

By signing below I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

Name & Credentials: _____ NPI: _____

Signature: _____
(Stamped signature not accepted)

Signature Date: _____

Phone: _____

Fax: _____