PROVIDENCE HOME MEDICAL EQUIPMENT	
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 opt. 4 Fax: (503) 215-4454	**Salem Location:** 2508 Pringle Road Salem, OR 97302 Phone: (503) 585-4027

Diabetic Supply Prescription Referral Form

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**
Address:	**Apt. #:**	**City/State/Zip:**
Alternate Contact/Relationship:		**Alt. Phone #:**
Primary Insurance Plan:	**Ins. ID#:**	**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**	**Group #:**
Subscriber Name:	**Relationship:**	**Subs. DOB:**
Primary Care Physician (if diff.):	**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: ☐ Life Time or ☐ Other: **Effective Date:** [if different than signature date]

Diabetic Testing Supplies:

- ☐ Test Strips
- ☐ Lancets
- ☐ Lancing Device
- ☐ Control Solution
- ☐ Syringes: _____ CC _____ G _____ mm *or* _____ in.
- ☐ Pen-needles: _____ G _____ mm *or* _____ in.
- ☐ Batteries
- ☐ Other Supplies: ______________________________

Check only if brand or size substitutions are **not** allowed: ☐

Glucometer:

- ☐ Accu-Chek Nano
- ☐ Accu-Chek Aviva Plus
- ☐ _______________ meter provided at clinic
- ☐ Other: ________________________________

____

Testing Frequency:

- ☐ 1 x per day
- ☐ 2 x per day
- ☐ 3 x per day
- ☐ 4 x per day
- ☐ 5 x per day
- ☐ 6 x per day
- ☐ 7 x per day
- ☐ 8 x per day
- ☐ _______________ x per day

Is the patient insulin dependent?

☐ No ☐ Yes, insulin pump

☐ Yes, injects _____ x per day (Syringes: x _____ and/or Pen-needles: x _____)

*****HIGH UTILIZATION*****

If ordering:

- **> 1 x per day** for **non-insulin** dependent
- **> 3 x per day** for **insulin**-dependent
- **> 4 x day** for **gestational diabetics**

Please complete the High Utilization narrative below ↓ for insurance approval.

Diagnosis:

- ☐ E10.9 Type 1 DM w/o complications
- ☐ E11.9 Type 2 DM w/o complications
- ☐ E10.65 Type 1 DM with hyperglycemia
- ☐ E11.65 Type 2 DM with hyperglycemia
- ☐ O24.419 Gestational diabetes

*If gestational, est. due date (EDC):_________

☐ Other ICD-10 Code(s): _________________

*****REQUIRED INFORMATION FOR HIGH UTILIZATION*****

Has the patient been seen in the last 6 months regarding their diabetes? ☐ Yes, date seen: __________ ☐ No ⬅

Is there documentation within the patient's chart (i.e. patient logs) to support the additional testing? ☐ Yes ☐ No ⬅

Check if patient recently had: ☐ Abnormal A1c ☐ Irregular blood glucose ☐ Medication adjustment ☐ Poor DM control

Physician's Narrative:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN'S SIGNATURE AND DATE]

Physician Printed Name:	**NPI#:**
➡ **Physician Signature: X**	**Date:** ⬅

Please attach supporting documentation (chart notes, blood glucose logs) & fax to 503-215-4454

THANK YOU FOR CHOOSING PROVIDENCE HOME SERVICES