HOME CARE DELIVERED®
Your Trusted Partner for Medical Supplies

Your HCD Contact:
Name, Account Executive
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Physician's Order for Continuous Glucose Monitoring, Insulin Pump, and Diabetic Supplies

Please provide patient demographics and most recent chart notes with order.

Start Date: | **Length of Need:**

PATIENT INFORMATION:

Patient Name: _____

DOB: ____ / ____ / ____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Insurance Plan Name:

_____

Member ID #: _____ Group Plan #: _____

PHYSICIAN INFORMATION: NPI: _____

Physician Name: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Step 1

Diagnosis ICD-10: E10.65 E10.9 E11.9 **Other** _____

Date patient last seen: _____ / _____ / _____

A1C: _____

Fasting Hyperglycemia mg/dL: _____

Step 2

Patient currently using insulin? YES NO

OR

Patient on insulin pump? YES NO

Administration frequency: _____ **times per day**

Fluctuation of BG level: **Low mg/dL:** _____

High mg/dL: _____

Step 3

Testing frequency: _____ **times per day**

Currently on CGM therapy? YES NO

Date first CGM received (optional): _____

Patient is motivated and knowledgeable to use a CGM or Insulin Pump, and adheres to a diabetes treatment plan? YES NO

Step 4

Continous Glucose Monitoring (CGM) Supplies:

- Non-adjunctive Receiver ___ per ___ month
- Non-adjunctive Transmitter ___ per ___ month
- Non-adjunctive Sensors ___ per ___ month

Dexcom sensors: changed every 10 days
Libre sensors: changed every 14 days

Insulin Pump & Supplies:

Insulin pump / Omnipod PDM	E0784	___ per ___ month
Infusion set, non-needle	A4230	___ per ___ month
Reservoir syringe w/ needle	A4232	___ per ___ month
Infusion set, needle type	A4231	___ per ___ month
Omnipod pods	A9274	___ per ___ month

Step 5

Please indicate brand preference: _____

Step 6

Other Supplies Required:

HCPC Code	Description	Freq. of Use	QTY/ days

By my signature below, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. For Medicare, Medicaid, or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Step 7

Date: _____ / _____ / _____ Physician Signature: _____

NPI: _____ Name Printed: _____