

Fax Form with Physician's Signature
to 888-565-4411 (toll-free fax)

Physician Completes Sections B-H

A: Patient Data:

Name: _____ Phone: (____) _____ Date of Birth: ____ / ____ / ____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Language: English Spanish Other _____ Insurance: Medicare Other _____

B: Diagnosis: (please select all that apply)

DIABETES MELLITUS ICD-9 DIAGNOSIS

- 250.01 Type I** - w/o complication, not stated as uncontrolled
- 250.03 Type I** - w/o complication, uncontrolled
- 250.00 Type II** - or unspecified type, w/o complication, not stated as uncontrolled
- 250.02 Type II** - or unspecified type, w/o complication, uncontrolled
- Other** _____

Additional Complication:

- 369.00** - Blindness of both eyes (in addition to one of the 250.xx codes above)

C: Testing Times

Test strips/lancets prescribed for 90-day period: (Select quantity)

- 1x/day = 100 2x/day = 200 3/day = 300
- 4x/day = 400 5x/day = 450 other: _____

- Has the patient/caregiver received instructions for using ordered item(s)? Yes No

D: Diabetes Testing Supplies Required:

(Select supplies needed)

- Home Blood Glucose Monitor-E0607 Lancing Device-A4258
- Blood Glucose Test Strips-A4253 Control Solution-A4256
- Lancets-A4259 Meter Battery-A4254
- Syringes-A4206 Voice Synthesized Blood Glucose Monitor-E2100

E. Duration of Need: 99 mo. - lifetime
 other _____

- I have seen the patient in the last 6 mo. Y N
- Patient currently using insulin Y N
- Insulin injecting frequency _____

F: For High Frequency Testers Only:

Medicare defines high frequency as insulin treated testing more than 3 times per day and non-insulin treated testing more than one time per day.

Reasons for high frequency testing: (REQUIRED BY MEDICARE)

- Frequency low blood sugars Pregnancy
- Frequency high blood sugars Intensive Treatment
- History ketoacidosis Other _____

G: Physician Information:

Physician's Name: _____
 Address: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Fax: _____
 NPI #: _____
 License #: _____ Exp Date: ____ / ____ / ____

H: Physician Signature:  _____ **Date:**  ____ / ____ / ____

*I certify that the ordered DME and supplies are part of my treatment plan and, in my professional opinion, are medically necessary.

PATIENT COMPLETES

Assignment of Benefits (AOB)

I request that payment of my insurance benefits (Medicaid, Medicare, Medicare Supplemental or other) be made to **Home Care Delivered Inc.** for any supplies or services furnished to me by **Home Care Delivered Inc.** I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of medical information about me to release to **Home Care Delivered Inc.** any information needed to determine benefits payable for these supplies or services. In addition, I authorize **Home Care Delivered Inc.** to release my medical records to insurers as well as medical professionals in my care and/or make said copies. I authorize **Home Care Delivered Inc.** to contact me by telephone, e-mail or mail regarding my medical supplies.

Patient Signature:  _____ **Date:**  ____ / ____ / ____

***** If Patient is unable to sign, Authorized Representative completes this section *****

Indicate reason patient cannot sign: _____

Name of Authorized Representative: _____ Date: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Signature of Authorized Representative: _____ Phone: (____) _____