

First Class Medical Equipment and Supply, Inc.

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**DOCTOR ORDER
Diabetes testing Supplies**

Patient Name: _____ **D.O.B.:** _____

Insurance: _____ **Insurance ID:** _____

DIAGNOSIS:

- NIDDM (ICD9: 250.00) IDDM (ICD9: 250.01)
 NIDDM, Uncontrolled (ICD9: 250.02) Other Specufy: _____

Is Patient Treated with Insulin? Yes No

RECOMMENDED TESTING: (Medicare does not accept PRN)

- 1 Time/day 2 Times/day 3 Times/day Other (specify) _____

Medicare requires an explanation for testing more frequently than;
1x day non-insulin treated or 3x day insulin treated: therefore, I confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted below the reason(s) for high testing frequency.

I prescribe the following Diabetic Supplies, and have crossed out the items I am not prescribing.
Glucose monitor, test strips, lancets, control solution, lancet device, battery, alcohol wipes, insulin/syringes (if insulin injecting).

By my signature below, I confirm that the patient has diabetes and is/was being treated by me. All the information contained on this Doctor Order Form accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. For Medicare/Insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes. I Certify that the above-prescribed equipment/supplies/treatments are medically indicated, and in my opinion, are medically reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

PHYSICIAN SIGNATURE _____ DATE: ___/___/___

PHYSICIAN NAME: _____ TEL: _____

UPIN: _____ NPI: _____