



19 S. Dixie Highway  
 Lake Worth, FL 33460  
**(800) 920-0411**  
**FAX: (800) 977-7689**

**HOME GLUCOSE MONITOR AND/OR TESTING SUPPLIES**

**PROVIDER# 1022690001**

Medicare requires us to have this form in our records. Please circle or fill in the answers to the following questions (#1 through #7) regarding the patient named below. Please sign, date, fax and mail the ORIGINAL back to us at the address located above. Thank you for assisting our mutual patient!

INITIAL ( X ) RENEWAL ( ) REVISED ( ) Start Date of CMN:

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

PATIENT D.O.B.: \_\_\_\_\_

1) ICD-9 DIAGNOSIS: (Please Circle) 250.00 250.01 250. \_\_\_\_\_

2) Yes / No DOES PATIENT INJECT / PUMP INSULIN? (CIRCLE)

3) \_\_\_\_\_ HOW MANY TIMES PER DAY IS THE PATIENT EXPECTED TO CHECK HIS/HER BLOOD SUGAR? (PLEASE USE 1, 2, 3 ETC.)

4) Yes / No HAS THE PATIENT BEEN TREATED OR EVALUATED FOR THEIR DIABETES IN THE LAST 6 MONTHS?

5) Yes / No IS PATIENT OR CAREGIVER CAPABLE OF LEARNING THE PROPER OPERATION OF THE DEVICE DESIGNED FOR HOME USE?

6) PATIENT TESTS FREQUENTLY BECAUSE HE / SHE HAS: (PLEASE CHECK)  
 \_\_\_\_\_ FLUCTUATING BLOOD SUGAR LEVELS  
 \_\_\_\_\_ HYPOGLYCEMIA \_\_\_\_\_ HYPERTENSION \_\_\_\_\_ HYPERGLYCEMIA  
 \_\_\_\_\_ OBESITY  
 \_\_\_\_\_ OTHER: PLEASE DESCRIBE: \_\_\_\_\_

7) CMN VALID FOR: 12 mos 24 mos 36 mos other: \_\_\_\_\_

**SUPPLIES ORDERED: (Please indicate if there are any changes)**

✓	HOME GLUCOSE MONITOR	✓	LANCETS	✓	LANCING DEVICE	✓	PUMP SUPPLIES		
✓	TESTING STRIPS	✓	CONTROL SOLUTION	✓	SYRINGES	✓	INSULIN	✓	BATTERY

Physician Information:

First and Last Name:

Address:

City:

State, Zip:

Phone:

Fax:

**I certify that I am treating this patient and that the information provided is accurate.**

\_\_\_\_\_  
**Signature**

Dr. UPIN #: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. NPI: \_\_\_\_\_