# PATIENT INFORMATION FORM AND D.O. FOR HOME GLUCOSE MONITORS & SUPPLIES

Please review the Detailed Written Order for accuracy, make all appropriate corrections, and enter NPI, sign & date.

## SECTION 1: PATIENT INFORMATION - *Please Print*

**NAME** ______________________________________________________________ **DOB** _____/______/______

**ADDRESS**_________________________________ **CITY**____________________ **STATE**______ **ZIP**______

**TEL** _______-________-__________ **GENDER** MALE FEMALE

**INSURANCE PLAN**_________________________________ **PLAN ID** _______________________________

## SECTION 2: DOCTOR ORDER

1. **DIAGNOSIS:** **E11.9** **E10.9** **E11.65** **E10.65** **O99.810** **O24.418/O99.810** **Other:**_______
2. **ORDER LENGTH:** **LIFETIME,** or, if other, _______________(specify length in months, weeks or days)
3. **MOST RECENT HbA1c RESULT** ___________________ **DATE OF TEST:** _____/______/______
4. **LAST DATE DIABETES CONTROL EVALUATED AND CHARTED:** _____/______/______
5. **TREATMENT** with Insulin: Yes No
6. **TESTING REGIMEN:** __________time(s) per day.
7. **PLEASE PROVIDE DOCUMENTED REASON FOR THE ORDERED TESTING REGIMEN**
   Hypertension / High Blood Pressure    Fluctuating Blood Sugar Levels
   Adjusting Medication    Other:______________________
8. **DEVICE TRAINING:** Patient/Caregiver is capable of learning proper operation of Device? Yes No
9. **PRODUCT ORDER:** Patient is hereby ordered to receive the following supplies (in accordance with Medicare or insurance guidelines) in connection with the Telcare Blood Glucose Monitoring System.

**PLEASE CHECK OFF ITEMS YOU WISH TO ORDER**.

**ALL ITEMS LISTED BELOW**

**Home Blood Glucose Testing Device** (Meter)
**Test Strips/Cartridges** (per testing regimen and actual use)
**Testing Device Control Solution** (per mfg.)
**Lancets** (per testing regimen and actual use)
**Spring Powered Lancet Device**

## SECTION 3: PHYSICIAN INFORMATION - *Please Print*

**DOCTOR** ________________________________________ **PRACTICE NAME** _________________________________

**ADDRESS** ____________________________ **City** ____________________________ **State** ______ **Zip** _____________

**TEL** _______-________-__________ **FAX** _________-________-__________

**EMAIL** _______________________________________ **NPI** _____________________________________

*By signing below, I confirm the medical supplies and/or medication indicated herein are medically necessary. I will furnish substantiating medical records upon request. I confirm that I have seen this patient within the last 6 months to evaluate their diabetes control.*

**DATE** _____/______/______ **PHYSICIAN SIGNATURE** _________________________________________________

MM/DD/YYYY – *Stamps NOT accepted*    *Stamps NOT accepted*

When completed, please fax to **(978) 832-1071**. THANK YOU

**Telcare Medical Supply**
**150 Baker Avenue Extension, Suite 300, Concord, MA 01742**
**Phone: 978.610.2230**