



PLEASE FAX TO:
(888) 613-5719

RX FOR DIABETIC SUPPLIES

PRESCRIPTION DATE:

PT ID:

<p>A. PATIENT INFORMATION</p> <p>Name: _____ Address: _____</p> <p>Phone#: _____ DOB: _____</p>	<p>B. PHYSICIAN INFORMATION</p> <p>Name: _____ Address: _____</p> <p>NPI: _____ PHONE#: _____ FAX#: _____</p>
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Step 1

C. DIAGNOSIS

E11.9 Type 2 NDDM (Controlled) E10.9 Type 1 IDDM (Controlled)
 E11.65 Type 2 NDDM (Uncontrolled) E10.65 Type 1 IDDM (Uncontrolled) Other: _____

Step 2

D. INSULIN

Patient uses insulin injections: YES _____ x/day or NO

Step 3

E. TESTING FREQUENCY

1x/day 2x/day 3x/day 4x/day 5x/day Other: ____x/day

F. LENGTH OF NEED Start date is equal to the signature date

LIFETIME unless otherwise noted _____ Months (99=lifetime) unless otherwise specified: _____

G. SUPPLIES I prescribe the use of the following supplies and have crossed out the items I am not prescribing

Test Strips	Lancets	Control Solution	Battery
Glucose Monitor	Lancet Device	Insulin/Syringes	Alcohol Wipes

If following Medicare guidelines, quantities of supplies are as follows (90 day supply):
 Test Strips A4253, 1 billing unit = 50 test strips; Testing 1x/day = 100, 2x/day = 200, 3x/day = 300, 4x/day = 400, 5x/day = 450
 Lancets A4259, 1 billing unit = 100 lancets; Testing 1x/day = 100, 2x/day = 200, 3x/day = 300, 4x/day = 400, 5x/day = 500
 Glucose Meter E0607; 1x/5yr, Control Solution A4256; 1x/mo, Lancing Device A4258; 1x/6mo, Batteries A4233/A4235; 6mo/PRN

H. OVERUTILIZATION

The medical records for this patient substantiate the above prescribed testing frequency and the medical reason if the prescribed testing frequency exceeds Medicare utilization guidelines. Medicare requires an explanation for testing more frequently than: 1x/day non-insulin treated or 3x/day insulin treated: I have noted below the reason(s) for high testing frequency.

Fluctuating Blood Sugar Abnormal HbA1c Medication Adjustments
 Positive Urine Ketone Recurring Infections Other: _____

I. VISION IMPAIRMENT CERTIFICATION

I certify that the above patient has visual impairments (visual acuity of 20/200 or worse) that require the use of an E2100 Talking Blood Glucose Meter with special features to assist in monitoring of the patient's blood glucose levels.

Step 4

J. SIGNATURE & DATE - By signing below, I confirm the medical supplies and/or medication herein are medically necessary and that this prescription is valid for NextGen Medical Supplies, Inc. I have had a face-to-face encounter with this patient within the last 6 months and have documented the condition related to this order in their medical record. I will furnish substantiating medical records upon request.

Physician Signature: _____ Date: ____/____/____

Printed name and NPI required of signing physician if different from provider printed above

Printed Name: _____ NPI: _____