NextGen
Medical Supplies, Inc.

**PLEASE FAX TO:**
**(888) 613-5719**

# RX FOR DIABETIC SUPPLIES

**PRESCRIPTION DATE:**

**PT ID:**

| A. PATIENT INFORMATION | B. PHYSICIAN INFORMATION |
|---|---|
| **Name:**<br>**Address:**<br><br><br>**Phone#:**<br>**DOB:** | **Name:**<br>**Address:**<br><br>**NPI:**<br>**PHONE#:**<br>**FAX#:** |

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**

**LIFETIME** unless otherwise noted _____ Months (99=lifetime)

Start date is equal to the signature date 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** | **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.

**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.

Step 4

**Physician Signature:** _____ **Date:** _____/_____/_____

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

**Printed Name:** _____ **NPI:** _____

Customer Service: (888) 557-7085