

PHYSICIAN'S ORDER FOR HOME BLOOD GLUCOSE TESTING

Patient Name
Address
Phone
Date of Birth
HICN

American Diabetic Supply, Inc.
400 South Atlantic Ave. #108
Ormond Beach, FL 32176
Phone 1-800-453-9033
Fax 1-800-524-3808
NSC# 1064280001 Rep _____

In order for your patient to get reimbursed by Medicare and/or the insurance company, **PLEASE COMPLETE ENTIRELY, SIGN AND DATE. THANK YOU.**

Diagnosis Code: (check one)

_____ 250.00 _____ insulin treated or _____ non-insulin treated. (check one)
_____ 250.01 This patient has insulin treated diabetes (IDDM).
_____ 250.02 _____ insulin treated or _____ non-insulin treated. (check one)
_____ Other—Please specify ICD-9 and insulin usage _____

This patient or caregiver has learned the proper operation of the Glucose Monitor ___ Y ___ N

I authorize any necessary supplies and equipment for glucose testing including:

_____ Glucose Monitor _____ Test strips _____ Lancets _____ Lancing device _____ Control Solution

Glucose tests per day and test strips prescribed for a 90 day period. (please check one)

() 1 test per day=100 () 2 tests per day=200 () 3 tests per day=300
() 4 tests per day=400 () 5 tests per day=450 () Other _____

Reasons for high-frequency testing; (high frequency testing is greater than 1 test per day for NIDDM patients and greater than 3 tests per day for IDDM patients). Please check all that apply.

() Fluctuating blood sugar () Hypoglycemia () Uncontrolled blood sugar
() Medication adjustments () Hyperglycemia () Hypertension
() Obesity () Other _____

Date of last patient visit (MM/DD/YY) _____

ATTENDING PHYSICIAN'S SIGNATURE (X) _____

DATE _____

Physician Name	UPIN
Address	NPI
	Specialty
City, ST	Phone
ZIP	Fax