CGM Prescription

Phone 888-510-5100 • **Fax** 309-664-7931
Email orders@insurancecoveredcgm.com

Patient Name: ______________________ DOB: ______________

Address: ______________________ Parent/Guardian: ______________

Phone: ______________________ Email: ______________

Policy Holder Name: ______________________ Insurance Name: ______________

Policy ID #: ______________________ Policy Group #: ______________

Diagnosis / ICD-10 Codes:

☐ Type 1 diabetes mellitus w/o complications E10.9
☐ Type 1 diabetes mellitus w/ hyperglycemia E10.65
☐ Type 2 diabetes mellitus w/ unspecified complications E11.8
☐ Type 2 diabetes mellitus w/o complications E11.9
☐ Type 2 diabetes mellitus w/ hyperglycemia E11.65
☐ Other: ______________

PLEASE CHECK ALL BOXES BELOW FOR RECEIVER AND SUPPLIES

☐ **K0554 Therapeutic CGM Receiver / Monitor**
1 Reader/1095 Days
Length of Need: Lifetime unless specified otherwise: ______________

☐ **K0553 Therapeutic CGM Supplies**
1 Unit/30 Days (1 Unit = 1 month of sensors and supplies)
Length of Need: Lifetime unless specified otherwise: ______________

Current Insulin Regimen:

☐ Insulin Pump ☐ Multiple Daily Injections: ______________ Per Day
☐ Other: ______________

Prescribed Number of Glucose Tests Per Day: ______________

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.

Clinic Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

Physician Name: ______________________ NPI: ______________

Physician Signature: ______________________ Date: ______________

PLEASE EMAIL OR FAX THIS PRESCRIPTION WITH PATIENT INSURANCE / DEMOGRAPHICS

IFP 062922