

CGM & SUPPLIES SWO



Please return this completed form along with chart notes supporting diagnosis, reasons for prescribing and date of last face to face encounter in the last 6 months.

Fax: +1 (847) 873 8041 Email: swo@diabetesdme.com

Patient Information

Patient Name: Date of Birth:
Gender: M F Phone: Email:
Address: City: State: ZIP:
Primary Insurance: Primary ID:
Secondary Insurance: Secondary ID:

Physician Information

Physician Name: NPI:
Address: City: State: ZIP:
Office Contact: Phone: Fax:

Date of Last Face-to-Face: / /

Diagnosis E10.9 E11.65 E10.65 E11.8 E11.9 Other*2

Documented reasons for prescribing CGM^{†1,2} PLEASE ATTACH CHART NOTES WHEN FAXING THIS FORM

Insulin-treated History of problematic hypoglycemia

Select Device

Dexcom if no device specified

<input type="checkbox"/>	Dexcom G7 and Supplies	Dispense: 1 receiver, 9 sensors / 90 days Change: sensor every 10 days
<input type="checkbox"/>	FreeStyle Libre 3 reader and sensor	Dispense: 6 sensors / 84 days, or 7 sensors / 98 days Change: sensor / 14 days

Duration of need: LIFETIME (99) - unless specified otherwise:

I certify that I am the physician identified on this form and that by signing I acknowledge, as the patient's treating practitioner, that the patient has sufficient training to effectively use the CGM as prescribed.

Date: Physician Signature:

www.DiabetesDME.com
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*Check ICD-10 code list in the LCD-related Policy Article for applicable diagnoses. †See the Policy Specific Documentation Requirements section of the LCD-related Policy Article. 1. Local Coverage Determination, Glucose Monitors (L33822). <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33822>. 2. Glucose Monitor, Policy Article (A52464). <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464>.