CGM & SUPPLIES SWO

Diabetes DME

Fax: +1 (847) 873 8041

Please attach **CHART NOTES** confirming diabetes diagnosis, treatment necessity, recent face-to-face/telehealth visit, patient training, and hypoglycemia history (if applicable).

Patient Information

Patient Name: _____ Date of Birth: _____

Gender: ☐ M ☐ F Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: Traditional Medicare Only Medicare ID: _____

Secondary Insurance: _____ Secondary ID: _____

Date of Last Face-to-Face ___ / ___ / _____

Diagnosis ☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other*[2] _____

Improve Glycemic control since the patient

☐ Insulin-treated

☐ Had one Level 3 glycemic event (<54 mg/dl) that substantively altered the mental or physical state enough to require third party assistance.

☐ Had multiple Level 2 glycemic event (<54 mg/dl) despite multiple attempts to adjust medication or modify the treatment plan.

Select Device

Dexcom if no device specified

☐ **Dexcom G7 receiver and sensors**

☐ **FreeStyle Libre 3/3+ receiver and sensors**

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

Physician Information

Physician Name: NPI:

Address: City: State: ZIP:

Office Contact: Phone: Fax:

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 and that the CGM is intended for an on-label use case.

Date: _____ Physician Signature: _____

www.DiabetesDME.com

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