CGM & SUPPLIES SWO

DiabetesDME

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: [_____]

Phone: [_____]   Email: [_____]

Address: [_____]   City: [_____]   State: [____]   ZIP: [_____]

Primary Insurance: [_____]   Primary ID: [_____]

Secondary Insurance: [_____]   Secondary ID: [_____]

Date of Last Doctor Visit: [_____]

Diagnosis
☐ E10.9   ☐ E11.65   ☐ E10.65   ☐ E11.8   ☐ E11.9   ☐ O24. [_____]   ☐ Other*[2] [_____]

Documented reasons for prescribing CGM [†1,2]

☐ Insulin-treated   ☐ 1   ☐ 2   ☐ 3+ insulin administrations, or   ☐ Insulin pump
☐ History of problematic hypoglycemia

Select Device
Duration of need: LIFETIME (99) – unless specified otherwise: [_____]

	Device	Details
☐	FreeStyle Libre 3 reader and sensor	**Dispense:** 6 sensors / 84 days, or 7 sensors / 98 days **Change:** sensor / 14 days
☐	FreeStyle Libre 2 reader and sensor	
☐	Dexcom G7 and Supplies	**Dispense:** 1 receiver, 9 sensors / 90 days **Change:** sensor every 10 days
☐	Dexcom G6 and Supplies	**Dispense:** 1 receiver, 1 transmitter / 90 days, 9 sensors / 90 days **Change:** sensor every 10 days, transmitter every 90 days

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.

Date: [_____]   Physician Signature: [_____]

🌐 www.DiabetesDME.com   📞 +1 (847) 873-8040
📍 One Overlook Point Suite 657 Lincolnshire, IL 60069