

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:
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:

<input type="checkbox"/>	FreeStyle Libre 3 reader and sensor	Dispense: 6 sensors / 84 days, or 7 sensors / 98 days Change: sensor / 14 days
<input type="checkbox"/>	FreeStyle Libre 2 reader and sensor	
<input type="checkbox"/>	Dexcom G7 and Supplies	Dispense: 1 receiver, 9 sensors / 90 days Change: sensor every 10 days
<input type="checkbox"/>	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:

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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>.