Aptiva Medical

Toll-Free Fax: 1-888-570-2590
Toll-Free Phone: 1-800-632-0659

NEW PATIENT REFERRAL FORM

Continuous Glucose Monitoring

PATIENT SECTION

Patient Name	DOB
Phone	Email
Shipping Address	City, State, Zip

Primary Insurance		Secondary Insurance	
Subscriber Name	DOB	Subscriber Name	DOB
Id #	Group #	Id #	Group #

PHYSICIAN SECTION (Doctor Order Form)

Step 1: Diagnosis Code (Required)

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: __________

Step 2: Prescriber's Prescription (Check Products Prescribed)

☐ K0554 - Receiver (Monitor). Dedicated for therapeutic continuous glucose system - 1 each (EA)

☐ K0553 - Monthly supply allowance for therapeutic continous glucose system - 1 monthly supply (1 unit)

____ ____ - Length of Need in Months (99 = Lifetime)

Step 3: Statement of Medical Necessity (Please Answer All Questions Below)

(A) Currently in CGM Therapy? ☐ YES ☐ NO

(B) Currently on an Insulin Pump? ☐ YES ☐ NO

(C) Patient has been seen within the last 6 months? ☐ YES ☐ NO

(D) Patient injects insulin at least 3x daily OR currently on an insulin pump? ☐ YES ☐ NO

(E) Does the patient require frequent adjustment to their diabetes treatment regimen on the basis of CGM/BGM results? ☐ YES ☐ NO

CONTINUOUS GLUCOSE MONITOR (CGM) SELECTION

☐ Abbott Freestyle Libre 2 ☐ Dexcom G6 ☐ Abbott Freestyle Libre 14

I certify that (1) I am the Treating Physician of the Patient identified in the section above, (2) the information contained herein is true, accurate, and complete to the best of my knowledge and according to my last visit with the Patient, (3) I maintain and can provide medical records for the Patient identified in the section above that substantiate the information completed above, the patient's ability to use, and medical necessity for a therapeutic continuous glucose monitor and/or related monthly supplies, (4) I agree to provide copies of the supporting medical records, as requested by Aptiva Medical and required by Medicare, and (5) the Patient requires these products and I have not ordered these same products from another supplier for this Patient. This document serves as a Prescription/Order and Statement of Medical Necessity for the above referenced Patient.

Phys Name (printed):________________________ NPI #:____________ Phone:__________________

Phys Address:____ Fax:__________________

PRESCRIBER SIGNATURE ____________________ DATE __________

Liberty Medical, LLC d/b/a Aptiva Medical