

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		Subscriber Name	
DOB		DOB	
Id #		Id #	
Group #		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 continuous 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

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.

Physician Name (Print)	NPI #	Phone
Physician Address		Fax

PRESCRIBER SIGNATURE

DATE