Aptiva Medical

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

NEW PATIENT ORDER FORM
Continuous Glucose Monitoring

PATIENT SECTION

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

PHYSICIAN SECTION

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 monitoring system - 1 each

☐ K0553 - Supply allowance for therapeutic continuous glucose monitoring (CGM) - 1 month supply (1 unit)

__99__ - Length of need in months (99 = lifetime); default is 99 unless specified here: _____

Step 3: Statement of Medical Necessity (please answer all questions below)

(A) Patient is currently in CGM therapy? ☐ YES ☐ NO

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

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

(D) Patient's insulin treatment regimen requires frequent adjustments based on CGM/BGM results? ☐ YES ☐ NO

↳ If **NO**, have the patient's glucose levels remained in your established target range? ☐ 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 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 during this service period. 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 _____