PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________________

Primary Phone: ______________________ Secondary Phone: ______________________

Address: ______________________ City/State/Zip: ______________________

Primary Insurance: ______________________ ID# ______________________

Secondary Insurance: ______________________ ID# ______________________

Contact person (if other than patient): ______________________

REQUIRED INFORMATION FOR ALL PATIENTS

PLEASE COMPLETE THIS SECTION IN FULL

Date of Last Office Visit: ______________ Duration of Need (12 months unless other wise noted): ________

Type 1— IDDM Type 2—Pills, Diet, and/or Insulin Treated

E10.9 __ E11.9

E10.65 __ E11.65

Other ______ **Other** __________

HbA1c: ___________

Currently using a pump? YES **NO**

Currently on CGM Therapy? **YES** **NO**

Fasting Hyperglycemia: _________

Testing Frequency: ____________

Using insulin shots to control? **Yes** **No**

Number of injections a day: ____________

Fluctuation of blood glucose values:

Low: ___________ High: ___________

- ☐ Test Strips

Product Name:

____

- ☐ Lancets

Product Name:

____

- ☐ Lancing Device **PRN**
- ☐ Ketostix
- ☐ Alcohol Wipes
- ☐ Meter Battery **PRN**
- ☐ Control Solution **PRN**
- ☐ Meter **PRN**

- ☐ Transparent Tape
- ☐ Prep Wipes
- ☐ Adhesive Remover
- ☐ Infusion Sets
- ☐ Reservoirs
- ☐ Omnipod Insulin Pump PDM
- ☐ Omnipod Pods

Tandem T-Slim Insulin Pump

Basal IQ

Control IQ

Other: _____________

CGM Products

DEXCOM G6

Receiver: Dispense 1: DME Only : 1/5 years

Sensors: Quantity 13 boxes (units): DME Only**:** 9 units/90 days

Transmitter Dexcom G6 (3 month use): 4/365 Days

FREE STYLE LIBRE 2

Receiver: Dispense 1: DME Only: 1/5 years

Sensors: Quantity 26.00 units: 6 units/90 days

USE PER MANUFACTURER RECOMMENDATIONS

My signature below denotes to the best of my knowledge the patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of supplies or equipment ordered. I am a provider who manages patients with diabetes, insulin pump, or CGM therapy and work closely with a team including nurses, diabetic instructors, and dietitians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

Physician Staff Contact:

____

Provider Name (print): ______________________ **Provider NPI #** ______________________

Provider Phone Number: ______________________ **Provider Fax:** ______________________

Provider Signature: ______________________ **Date:** ______________

MEDICARE CLINICAL DOCUMENTATION CHECKLIST FOR AIM PLUS MEDICAL SUPPLIES, LLC

The following must be completed and signed by the physician with supporting documentation.

CONTINUOUS GLUCOSE MONITORS (CGM) PREREQUISITE CRITERIA

***Please check all that apply and include supporting documentation.**

Therapeutic CGMs and related supplies are covered by Medicare when all of the following coverage criteria (1-6) are met:

___ The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,

___The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a Medicare-covered continuous subcutaneous insulin infusion (CSII) pump; and,

___The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results; and,

___Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate their diabetes control and determined that criteria (1-4) above are met; and,

___Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment.

When a therapeutic CGM (code K0554) is covered, the related supply allowance (code K0553) is also covered.

If any of coverage criteria (1-5) are not met, the CGM and related supply allowance will be denied as not reasonable and necessary.

INSULIN PUMPS COVERAGE CRITERIA

***Please check all that apply and include supporting documentation.**

___ Must have completed a comprehensive diabetes education program.

___ Must have a diagnosis of diabetes

___ Must be injecting at least 3X per day and adjusting insulin dose

___ Lab work is required

___ Must be testing4X per day (or on a CGM) and meet one of the following criteria:

1. HbA1C greater than 7%
2. History of recurring hypoglycemia
3. Wide fluctuations in blood glucose before mealtime
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
5. History of severe glycemic excursions

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by CMS. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

____ ___________________________

Prescribing Practitioner Signature (Required) Date

Stamps/copies of the physician's signature will not be accepted.