Diabetic Testing, Insulin Pump and Supplies, CGMs
Detailed Written Order – Medicare

Please Fax Form with Physician's Signature to
1-866-496-7054 AIM Plus Medical Supplies

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____ ID# _____

Contact Person (if other than patient): _____

REQUIRED INFORMATION FOR ALL PATIENTS
PLEASE FULLY COMPLETE THIS SECTION

Date of Last Office Visit: _____

Duration of Need (12 mo. Unless Otherwise Noted): _____

Type 1 - IDDM	Type 2- Pills, Diet, and/or Insulin Treated
☐ E 10.9	☐ E 11.9
☐ E 10.65	☐ E 11.65
☐ E 10.649	☐ Other _____

HbA1c: _____

Currently Using a Pump? ☐ Yes ☐ No

Currently on CGM Therapy? ☐ Yes ☐ No

Fasting Hyperglycemia: _____

Testing Frequency: _____ X Per Day

Fluctuation of Blood Glucose Values:

Using Insulin Injections to Control? ☐ Yes ☐ No

Low: _____ High: _____

Number of Injections: _____ X Per Day

PRODUCTS- USE PER MANUFACTURERS RECOMMENDATION

☐ CGM, Dexcom G6: Sensors, transmitter, receiver, prep wipes, adhesive remover, dressing, glucometer, test strips, lancing device, lancets, control solution – PRN

☐ CGM, Dexcom G7: Sensors (transmitter included), receiver, prep wipes, adhesive remover, dressing, glucometer, test strips, lancing device, control solution – PRN

☐ CGM, FreeStyle Libre 2: Sensors, Reader, prep wipes, adhesive remover, dressing, glucometer, test strips, lancing device, lancets, control solution- PRN

☐ Insulin Pump:
☐ Tandem T-slim Control IQ
☐ Tandem T-slim Basal IQ
☐ Medtronic MiniMed 630G
☐ Medtronic MiniMed 770G

☐ Insulin Pump Supplies: Reservoirs, infusion sets, prep wipes, adhesive remover, dressing- PRN

☐ Other: _____

*Items may be substituted as appropriate.

**My signature below denotes to the best of my knowledge the patient/caregiver can 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 dieticians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

PLEASE PRINT NAME, SIGN, AND DATE

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 (1-5) 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.

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.