

**PHYSICIAN'S ORDER FOR  
HOME DIABETES TESTING SUPPLIES**



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Altamonte Springs, FL 32701  
Phone: 407-849-6455  
Fax: 407-849-6458

EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_

**Patient Information:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_

**Physician Information:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
NPI: \_\_\_\_\_ License #: \_\_\_\_\_

*All Sections must be completed. Please sign and date any changes you make to this information.*

**DIAGNOSIS INFORMATION**

Length of need: 12 Months unless otherwise specified: \_\_\_\_\_

<input type="checkbox"/> Non-Insulin Dependent 250.00	<input type="checkbox"/> Insulin Dependent 250.01	<input type="checkbox"/> Gestational Diabetes 648.80	<input type="checkbox"/> Other - - - - -
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**BLOOD GLUCOSE METER SUPPLIES**

Blood Glucose Meter     Test Strips     Lancing Device     Lancets     Glucose Meter Battery     Control Solution  
 Other \_\_\_\_\_

Is patient injecting insulin to control their diabetes?    Yes \_\_\_\_\_    No \_\_\_\_\_

**Patient is being prescribed to test their blood sugar levels at home (X's / day)**

<input type="checkbox"/> 1 x/day – 100 strips, lancets/3 months	<input type="checkbox"/> 2 x/day – 200 strips, lancets/3 months	<input type="checkbox"/> 3 x/day – 300 strips, lancets/3 months
<input type="checkbox"/> 4 x/day – 400 strips, lancets/3 months	<input type="checkbox"/> 5 x/day – 500 strips, lancets/3 months	<input type="checkbox"/> 6 x/day – 600 strips, lancets/3 months
<input type="checkbox"/> 7 x/day – 700 strips, lancets/3 months	<input type="checkbox"/> 8 x/day – 800 strips, lancets/3 months	<input type="checkbox"/> 9 x/day – 900 strips, lancets/3 months
<input type="checkbox"/> Other _____ x/day _____ strips/lancets/3 months		

**FOR HIGH FREQUENCY TESTING REGIMEN**

Medicare requires an explanation for testing more frequently than; **1 x/day non-insulin treated or 3 x/day insulin treated;** therefore, confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted below the reason(s) for high testing frequency.

**I am prescribing the above indicated home blood glucose testing regimen because:**

<input type="checkbox"/> There is a large fluctuation in the level of blood sugar	<input type="checkbox"/> To control hypoglycemia states after meal
<input type="checkbox"/> In order to avoid episodes of nighttime hypoglycemia	<input type="checkbox"/> Patient does not have control of their diet
<input type="checkbox"/> Other (please explain) _____	

*Physicians please note: No product authorized herein will be supplied without the consent of the patient.*

**BY SIGNING BELOW, I AM STATING THAT:** I am or was this patient's treating physician during the order period. This order accurately reflects the patient's condition, my prescription for home blood glucose testing, and is substantiated by medical records. The patient or their caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. **I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

X \_\_\_\_\_  
*Physician Signature* *Date*