



P.O. Box 5771
Winter Park, Florida 32793-5771
Phone: (407) 365-7580

Provider # 0255470001

Patient Name: _____

Initial Renewal Revised

Address: _____

RX Period From: _____ To: _____

ID: _____

Est. Length of Need (# Months): _____
1-99 (99=Lifetime)

HICN: _____

Height: _____ Weight: _____

Diagnosis: _____

Prognosis: _____

Equipment Prescribed: _____

DIABETIC TESTING SUPPLIES

Please confirm with your signature that the following statements are correct.

Patient is being treated for diabetes and is (circle one) **INSULIN TREATED** **ON ORAL MEDICATION**
(ICD9 code 250.01) (ICD9 code 250.00)

Patient/caregiver has been taught how to use the equipment in the home and is able to use blood glucose results to help control their diabetes.

Patient has visited you within the last six (6) months for the purpose of evaluating diabetes control. Date: _____

Please indicate one or more of the following conditions is documented in the patient's records:

- _____ Evidence of poor diabetic control due to frequent insulin reactions
- _____ Evidence of poor diabetic control due to widely fluctuating blood sugars
- _____ Peripheral neuropathy with evidence of callus formation
- _____ History of pre-ulcerative calluses
- _____ History of previous ulceration
- _____ foot deformity
- _____ previous amputation of the foot or part of the foot
- _____ poor circulation

There are no severe visual impairments (20/200 or worse) that would require a voice-based meter.

Number of daily glucose level checks needed?: _____

Physician: _____

Phone: _____

Address: _____

Fax: _____

UPIN: _____

Verify the medical necessity of these items for this patient. Attending Physician, Please Sign Below.

Signature: _____ Date: _____