



830 Eyrie Dr., Suite 6B  
Oviedo, Florida 32765  
Phone: 800-330-2313  
Fax: 866-413-5202

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: \_\_\_\_\_

NPI: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Central Medical Systems, LLC

830 Eyrie Drive – Suite 6B - Oviedo, FL 32765

407-365-7580 / 800-330-2313

## AUTHORIZATION and AGREEMENT FOR SERVICES

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( \_\_\_ ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received the statement of rights and responsibilities and it has been explained to me.

### AUTHORIZATION FOR SERVICES

I authorize **CENTRAL MEDICAL SYSTEMS, LLC** to provide supplies and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment or medical supplies.

### PATIENT HEALTH INFORMATION and SUPPLIER STANDARDS

My signature below acknowledges that I have received the brochure explaining **CENTRAL MEDICAL SYSTEMS, LLC** patient health information privacy policy and CMS (Medicare) Supplier Standards.

### ASSIGNMENT OF BENEFITS

I authorize payment directly to **CENTRAL MEDICAL SYSTEMS, LLC** of any benefits otherwise payable in respect to examination or treatment of client. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law. Primary Insurance pays for 80 %. Client is responsible for 20% of approved charges and any unpaid annual deductible. **I understand that Medicare or my primary insurance will only cover for products it deems "medically necessary" and payments made by Medicare is based on their regulations, utilization limits and fee schedules.**

### EMERGENCY PLAN

My signature below acknowledges that I have established and understand my emergency plan. I have received **CENTRAL MEDICAL SYSTEMS, LLC's** brochure; I have been informed of the nature and procedure to request additional supplies I may need; and I have participated in the planning of my care. There are no home visits appropriate for the care provided.

### RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under a policy of insurance is correct. I authorize the home care company or any other holder of medical or other information about the above named client, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above client; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the client or providing continuity of care; and to quality reviewers.

✓

\_\_\_\_\_  
Signature of Patient or Responsible Person

\_\_\_\_\_  
Date