HLMS HEALTHY LIVING MEDICAL SUPPLY

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Medicare Detailed Written Order for Therapeutic CGM

Order/Start Date: ___/___/___

	Freestyle Libre reader and all monthly supplies	Estimated length of need (# of months)
	Dexcom receiver and all monthly supplies	_____ 1-99 (99=lifetime)

Patient Information

Patient Name:	Date of Birth:
Address:	City:
State: Zip:	Phone:
Email:	Secondary Phone:

Insurance

Primary Insurance:	Secondary Insurance:
Member ID:	Member ID:

Currently on CGM Therapy? ☐ Yes ☐ No

On Insulin Pump? ☐ Yes ☐ No

#SMBG: _____ per day

 # Multiple Daily Injections:
_____ per day

Date of Last Visit: (must be within 6 months of this order)
_____

Diagnosis Code ICD-10:

☐ E10.65 ☐ E10.9 ☐ E11.9

☐ Other: _____

Physician Information:

Physician Name:	Physician or Office Email:
NPI:	Hospital/Clinic:
Address:	State:
City:	Zip:
Phone:	Fax:

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom or Abbott Continuous Glucose Monitoring System.

I certify that I am the physician identified on the above section and I certify that the medical necessity contained in this document is true, accurate, and complete, to the best of my knowledge.

Signature:	**Date:**

Please send completed form to cgm@myhlms.com or fax to 866.779.8511.