HLMS HEALTHY LIVING MEDICAL SUPPLY

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Diabetes Supply Prescription/Referral Form

Referred by:	Date:	
Name:	Date of Birth:	Sex: Male ☐ Female ☐
Address:	City:	State: Zip:
Email:	Phone (Cell):	Phone:

Insurance:

Primary Insurance:	Secondary Insurance:
Policy ID:	Policy ID:

☐ Patient is aware of referral to Healthy Living Medical Supply. ☐ Patient has been seen in the last 6 months.

Duration of Need:

☐ 12 months ☐ Other: _____ (12 months unless otherwise noted.)

Diagnosis Code: (Please check all appropriate boxes.) ☐ Preexisting ☐ New

Is patient treated with insulin? ☐ YES (Z79.4) ☐ NO

Type 1 = ☐ E10.9 (no complication) ☐ E10._____ (list additional digits to specify complications)

Type 2 = ☐ E11.9 (no complication) ☐ E11._____ (list additional digits to specify complications)

☐ Other: _____ Gestational = _____ Due Date: _____
(ICD-10 Code)

Diabetes Testing Supplies:

☐ Test Strips ☐ Lancets ☐ Alcohol Pads ☐ Control Solution ☐ Syringes: _____ QTY
☐ Other: _____ *Glucose Monitor: ☐ HAS ☐ NEEDS

Recommended Testing Frequency:

☐ 1 time/day = up to 50 test strips & 100 lancets/mo
☐ 2 times/day = up to 100 test strips & 100 lancets/mo
☐ 3 times/day = up to 100 test strips & 100 lancets/mo
☐ 4 times/day = up to 150 test strips & 200 lancets/mo
☐ 5 times/day = up to 150 test strips & 200 lancets/mo
☐ 6 times/day = up to 200 test strips & 200 lancets/mo
☐ Other: _____ times/day QTY: _____

Insulin Pump: ☐ YES ☐ NO

Pump & CGM Supplies:

☐ Infusion Sets, QTY _____ ☐ Reservoirs, QTY _____
*Frequency of **infusion site changes**: 1x every _____ days (Default is every 3 days.)*
☐ Sensors ☐ Transmitter
*Frequency of **sensor changes**: 1x every _____ days (Default is every 6 days.)*
☐ IV Prep Wipes ☐ Transparent Dressing
☐ Other: _____

Physician Information:

Physician Name:	Physician or Office Email:
NPI:	DEA:
Address:	State:
City:	Zip:
Phone:	Fax:
Physician Signature:	**Date Signed:**