LNS MEDICAL SUPPLY
We Care About Your Health!

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PATIENT ORDER FORM

Continuous Glucose Monitor Order Form

PATIENT SECTION			
Patient Name:		**Start Date:**	
Gender:		**Date of Birth:**	
Primary E-mail:		**Mobile Number:**	
Shipping Address:		**Home Number:**	
		Work Number:	

PHYSICIAN SECTION

Step 1: Diagnosis Code (required):
☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Step 2: Prescriber's Prescription (check products prescribed)
☐ E2103 - Receiver (monitor) - 1 each per month / 1 every 5 yrs
☐ A4239 - Continuous Glucose Sensor - 1 each per month / 3 per 3 months

Step 3: Statement of Medical Necessity (please answer all questions below)
Patient is currently in CGM therapy? ☐ YES / ☐ NO
Patient has been seen within the last 6 months? ☐ YES / ☐ NO
Patient injects insulin at least 3x daily OR is currently on an insulin pump? ☐ YES / ☐ NO
Patient's insulin treatment regimen require frequent adjustments based on CGM/BGM results? ☐ YES / ☐ NO
If NO, have the patient's glucose levels remained in your established target range?
☐ YES / ☐ NO

99 - Length of need in months (99 = lifetime); default is 99 unless specified here: _____

I certify that (1) I am the treating physician of the patient identified in the section above, (2) the information contained herein is true, accurate, and complete to the best of my knowledge and according to my last visit with the patient, (3) I maintain and can provide medical records for the patient that substantiate the information completed above, the patient's ability to use, and medical necessity for a therapeutic continuous glucose monitor and/or related monthly supplies, (4) I agree to provide copies of the supporting medical records, as requested by LNS Medical Supply and required by Medicare, and (5) the patient requires these products and I have not ordered these same products from another supplier for this patient during this service period. This document serves as a prescription/order and statement of medical necessity for the above-referenced patient.

Physician:	**NPI #:**	**Phone Number:**	
Office Address:		**Fax Number:**	
PRESCRIBER SIGNATURE		**DATE**	

*****NO STAMP ON SIGNATURE LINE*****

WEB