MAIL ORDER MEDICAL SUPPLIES

Fax: 1-877-243-5077
Phone: 1-877-246-7980
Account Manager: Jack
Email: Jack@moms23.com

Detailed Written Order
Continuous Glucose Monitor/Supplies

PATIENT SECTION

Patient Name	DOB
Phone	Alt Phone
Shipping Address	City, State, Zip

PHYSICIAN SECTION

Step 1: Diagnosis Code (required)

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Step 2: Prescriber's Prescription (strike products NOT prescribed)

E2103 - Receiver (Monitor), for non-adjunctive continuous glucose monitoring system – 1 each

A4239 - Monthly supply allowance for non-adjunctive continuous glucose monitoring system – 1 month supply (1 unit)

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

Step 3: Statement of Medical Necessity (please answer all questions below)

(A) Patient is currently in CGM therapy? ☐ YES ☐ NO

(B) Patient has been seen within the last 6 months? ☐ YES ☐ NO

(C) Patient is treated with insulin injections/inhalation OR is currently on an insulin pump? ☐ YES ☐ NO

↳ If **NO,** does patient have at least one of the following?

☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; OR,

☐ A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia

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 Mail Order Medical Supplies and required by Medicare, (5) the patient requires these products and I have not ordered these same products from another supplier for this patient during this service period, and (6) I certify that Mail Order Medical Supplies may contact my patient in regards to products authorized on this document. This document serves as a prescription/order and statement of medical necessity for the above-referenced patient.

Physician Name (print)	NPI #	Phone
Physician Address		Fax

PRESCRIBER SIGNATURE _____ **DATE** _____