

Test Results for the Month: _____, 20____

Help desk: 1.800.384.1604 Fax: 1.800.384.3416
Hearing impaired line: 711

Signature _____ Date _____

Day	1 st Test		2 nd Test		3 rd Test		4 th Test		5 th Test		6 th Test		7 th Test	
	Time	Result	Time	Result	Time	Result	Time	Result	Time	Result	Time	Result	Time	Result
1														
2														
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31														

The number of times you are testing daily should match the frequency prescribed by your doctor to help ensure Medicare coverage of your supplies. When complete, please sign and date, moisten glued edges, fold in half to seal and mail or fax to: 1.800.384.3416