Provider Data Submission Tool Based on Anthem Corporate Medical Policy DME.00005

Subject:	**Glucose Monitoring and Related Supplies**		
Effective Date:	3/24/2004	**Last Review Date:**	5/15/2008
Policy Effective Date:	7/9/2008		

Please refer to the last page of this document for the appropriate fax and/or mail address for your member.

Patient Name _____

Date of Birth _____

Insurance Identification Number: _____

Member Phone Number: _____

Ordering Physician Name & Specialty _____

Physician Office Address: _____

_____

_____

Office Phone Number: _____

DME Vendor: _____

DME Vendor Office Address: _____

_____

_____

DME Vendor Office Phone Number: _____

Service Requested/CPT code(s): _____

Diagnosis/ICD-9 code(s): _____

Place of Service: _____

Date/Date Range of Service: _____

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Please check all that apply to the member:

_____ Request is for a FDA approved standard blood glucose monitor
_____ Request is for a Blood glucose monitor with special features to allow easy use for patients with severe visual impairment (20/200 or greater)
_____ Request is for any of the following supplies:
- _____ Blood glucose monitoring strips
- _____ Lancets, including spring-powered lancets
- _____ Replacement batteries, calibrator solution/chips

_____ Request is for intermittent, short-term use of continuous interstitial glucose monitoring device as an adjunct to standard care
_____ Request is for long-term use of continuous interstitial glucose monitoring device as an adjunct to standard care
_____ Request is for combination glucose/fructosamine home testing devices
_____ Request is for software/hardware required for downloading data from glucose monitor to computers
_____ Request is for Laser Lancets
_____ Request is for home hemoglobin A1c (HbA1c) or other glycosulated serum protein monitors
_____ Request is for a non-FDA approved glucose monitors, including those using infrared spectroscopy
_____Request is for continuous glucose monitoring system (e.g. Paradigm® REAL-Time System, which includes sensors and transmitters)
- _____This has wireless communication to a compatible external insulin pump and/or monitor

_____Member is currently using a functioning continuous glucose monitor
_____Member is currently using an external insulin pump with wireless integration capability
- _____Name or type of pump _____

_____Request is for the DexCom STS-7 System
_____Request is for the Guardian Real-Time System
_____Request is for equipment upgrades or accessories to integrate, through wireless communication technology, an insulin pump and interstitial glucose monitor.

The member has the following conditions: (check all that apply)
- _____ Member has Type 1 diabetes
- _____Member has Type 2 diabetes
- _____Member has gestational diabetes
- _____Member has diabetes secondary to other conditions
- _____Member has documented severe visual impairment of 20/200 or greater
- _____Member has a diagnosis of "impaired glucose tolerance" or "pre-diabetes"
- _____Member has inadequate glycemic control despite compliance with frequent self-monitoring (at least 4 times per day) and including fasting hyperglycemia (>150 mg/dl) or recurring episodes of severe hypoglycemia (<50 mg/dl). This poor control is in spite of compliance with multiple alterations in self-monitoring and insulin administration regimens to optimize care.
- _____Member is receiving insulin injections 3 or more times per day or an insulin pump is used for maintenance of blood sugar control.
- _____Member requires 4 or more fingersticks per day

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_____Member is under physician supervision, monitoring and interpretation
_____Device will be used for 72 consecutive hours on an appropriate, periodic basis
_____Request is for the first or second use of device this calendar year
_____Member has recurrent episodes of severe hypoglycemia with blood glucose less than 50mg/dL
_____Member with Type 1 diabetes who are pregnant and monitor will be used during the course of pregnancy

The information provided is true and accurate to the best of my knowledge. I understand that Anthem may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

_____ _____
Provider or Provider Representative Signature Date

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The following addresses and fax numbers are for submitting pre-claim requests. For post-claim requests, submit this form to the address or fax number identified in the request for additional information letter you received.

National Members Precertification and Predetermination Requests:
Fax: 317-287-5049 or 1-800-773-7797
Mail: Anthem UM Services, Inc
P.O. Box 7101
Mail point: IN0205-A546
Indianapolis, IN 46207-7101

Indiana Members Precertification Requests:
Fax: 317-287-8916
Mail: Anthem UM Services, Inc
P.O. Box 6220
Mail point: IN0205-A599
Indianapolis, IN 46206

Indiana, Kentucky, Missouri, Ohio and Wisconsin Members Predetermination Requests:
Fax: 888-656-5721 or 513-770-7589
Mail: Anthem UM Services, Inc
4361 Irwin Simpson Road
Mail point: OH0204-A102
Mason, Ohio 45040-9498

Kentucky Members Precertification Requests:
Fax 800-730-6061 or 502-889-2871
Mai: Anthem UM Services, Inc
13550 Triton Park Blvd.
Mail point: KY0304-A670
Louisville, KY 40223

Missouri Members Precertification Requests:
Fax: 314-923-8542
Mail: Anthem UM Services, Inc
1831 Chestnut
St. Louis, MO 63103-2275

Ohio Members Precertification Requests:
Fax: 1-800-266-3504
Mail: Anthem UM Services, Inc
4361 Irwin Simpson Road
Mail point: OH0204-A662
Mason, Ohio 45040-9498

Wisconsin Members Precertification Requests:
Fax: 866-959-2154
Mail: Anthem UM Services, Inc
N17 W24340 Riverwood
Waukesha, WI 53188