Physician Order - Diabetic Form

Fax form with physician's signature & date to 1-866-855-5888 (toll free fax)

Required Start Date: ____________

Patient Medicare ID: ____________ **Medicaid ID:** ____________ **(if applicable)**

Patient Name: ____________

Address: ____________

City: ____________ **State:** ____________ **Zip:** ____________

Phone#: ____________ **Gender:** ____________ **Birth Date:** ____________

1 → Diabetes ICD-9 Diagnosis

Diagnosis Code: _ _ _._ _ **Other :** _ _ _._ _

Diabetic Type: ____________

2 → Treated with Insulin Injections? _____ Y _____ N

Using Infusion Pump to Administer Insulin? _____ Y _____ N

3 → HBA1C Count ____________

4 → Testing Frequency ____________ times/day

Number of strips and lancets prescribed for a 90-day period equals
1x day=100 | 2x day=200 | 3x day=300 | 4x day=400 | 5x day=500

Approved Medicare Services:

Meter Control Solution Battery for Monitor Lancet Device

5 → Medicare Utilization Guidelines

Medicare requires an explanation for testing more frequently than 1x day non-insulin or 3x day insulin treated; therefore, I confirm that I have evaluated this patient within the last six (6) months to assess their diabetes control and have noted below the reason(s) for high testing frequency.

____

____

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

6 → Sign/Date and Provide Any Missing Information

Physician Name: ____________ **UPIN:** ____________ **NPI:** ____________

Address: ____________

City: ____________ **State:** ____________ **Zip:** ____________

Phone: ____________ **Fax:** ____________

Physician Signature: ____________ **Date:** ____________

[Original Signature and Date Required]

Mail Original Form To: **Walgreens Medicare Processing,** P.O. BOX 4000 DANVILLE, IL 61834-4000
Phone: 1-888-281-0590

Or Fax Form To: 1-866-855-5888

Store #: **Group #:**

PLEASE INITIAL AND DATE ALL CHANGES