



Please complete all numbered sections, sign and date the order form

**Fax # 1-866-494-0629**

1 Design Drive  
North Kansas City, MO 64116

Toll Free Phone: 1-800-503-7336

## Written Order Form - Diabetic Testing Supplies

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last Name First Name Middle Initial

**1** Diabetes Diagnosis Code (Medicare does not accept Pre-Diabetes OR Glucose Intolerance)

\_\_\_\_\_.\_\_\_\_\_.\_\_\_\_\_.\_\_\_\_\_.\_\_\_\_\_.\_\_\_\_\_. Specify Diagnosis Code - Must be between 249.00 and 250.93

**2** Please indicate the patient's testing frequency per day

**Non-Insulin** Treated  1x  More \_\_\_\_\_ (Medical Records REQUIRED prior to dispensing)  
Specify Frequency

**Insulin** Treated  1x  2x  3x  More \_\_\_\_\_ (Medical Records REQUIRED prior to dispensing)  
Specify Frequency

Supplies for 90-day period	1x	2x	3x	4x	5x
Diabetic Testing Strips	100	200	300	400	450
Lancets	100	200	300	400	500
Control Solution; Lancet Device; Glucose Monitor; Battery	1	1	1	1	1

**REVIEW** What is the most recent hemoglobin A1c results \_\_\_\_\_% \_\_\_\_/\_\_\_\_/\_\_\_\_ date

**3** Length of need is \_\_\_\_\_ months, if not specified, length of need is lifetime. (99 = Lifetime)

**4** I prescribe all of the following Diabetes Supplies: \_\_\_\_\_ (Please cross out the items you do NOT want dispensed)  
Glucose Monitor; Diabetic Test Strips; Control Solution; Lancet Device; Lancets; Battery

I certify and confirm the following statements (5 - 6):

**5** I am treating this patient under a comprehensive plan of care for diabetes.  Yes  No

**6** The patient, or caregiver, understands the proper use of the prescribed items and is capable of using the test results to assure appropriate blood sugar control.  Yes  No

By my signature below, I confirm that the patient has diabetes and is being treated by me. All the information contained on this Written Order Form accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed testing frequency and the reason for testing at the frequency listed above. For Medicare/Insurance requirements, I will maintain a signed original document in the patient's medical record file for post-payment review/audit purposes.

Print Name: \_\_\_\_\_ **8** NPI #: \_\_\_\_\_

**7** Signature\* (No Stamps) \_\_\_\_\_ **9** Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_

\*If the signing doctor is different than the listed doctor, please print your name and provide your NPI number.