

# The DiABETIC Shoppe

6629 MS Highway 32E ~ Charleston, MS 38921  
 Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-888-377-2224

## Diabetic Testing Supplies

Step 1

Patient ID#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Patient Name: Mr/Ms \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_, \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Step 2

PATIENT TESTING FREQUENCY	SUPPLIES ORDERED (Cross out items not needed.)
<input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day (see step 3) <input type="checkbox"/> 3x/day (see step 3) <input type="checkbox"/> 4x/day (see step 3) <input type="checkbox"/> ___ x/day (see step 3)	<input checked="" type="checkbox"/> Test Strips <input checked="" type="checkbox"/> Lancets <input checked="" type="checkbox"/> Lancing Device <input checked="" type="checkbox"/> Control Solution Monitor Type: _____ <input type="checkbox"/> Has <input type="checkbox"/> Needs

Step 3

\*Medicare requires a reason for high frequency testing which includes testing more than **1x DAY FOR NIDDM** treated **OR** more than **3x DAY FOR IDDM** treated patients. I confirm I have seen this patient within six months to evaluate their diabetes control & have identified the reason(s) for high testing frequency.

Uncontrolled Blood Sugar       Hypoglycemia       Hypertension  
 Fluctuating Blood Sugar       Hyperglycemia       Obesity  
 Other: \_\_\_\_\_

Is the patient treated with INSULIN  Yes  No      Diag:  25000  25002  25001  25003  \_\_\_\_\_

Syringes or  Pentips Units \_\_\_\_\_ Size \_\_\_\_\_

Length of need is lifetime per Medicare guidelines, unless otherwise specified:

\*The above information is true, accurate and complete to the best of my knowledge. By my signature below I certify that the patient has diabetes and is/was being treated by me, and has been seen in the last six months. All the information contained in this written Doctors 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. For Medicare / insurance requirements, I will maintain this signed original in the patient's medical record file.

Step 4

Print Physician's Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NPI: \_\_\_\_\_ City: \_\_\_\_\_, ST: \_\_\_\_\_



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**JCAHO**