The DiABETiC Shoppe
418 East Main Street ~ Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-888-377-2224

Diabetic Testing Supplies

Step 1

Patient ID#:____________________ Date:__________________________

Patient Name: Mr/Ms____ SS#:__________________________

Address:___________________________________ City:________________________,______ Zip:__________

Phone:___________________________________ Birthday:____

Primary:_________________________________ Secondary:____

Policy #:_________________________________ Policy #:____

Step 2

PATIENT TESTING FREQUENCY

- ❑ 1x/day
- ❑ 2x/day (see step 3)
- ❑ 3x/day (see step 3)
- ❑ 4x/day (see step 3)
- ____ x/day (see step 3)

SUPPLIES ORDERED
(Cross out items not needed.)

- ✓ Test Strips
- ✓ Lancets
- ✓ Lancing Device
- ✓ Control Solution

Monitor Type:________________ ❑ Has ❑ Needs

Step 3

*Medicare requires a reason for high frequency testing which includes testing more than **1x/DAY FOR NON-INSULIN** treated OR more than **3x/DAY FOR INSULIN** treated patients.

- ❑ Fluctuating Blood Sugar
- ❑ To Maintain Control
- ❑ Uncontrolled Diabetic
- ❑ Hypertension
- ❑ Brittle Diabetic
- ❑ Change of Medication
- ❑ Other____

Is the patient treated with INSULIN ❑ Yes ❑ No Diagnosis: ❑ 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:__________

Accredited by
JCAHO