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#:_____ Date:_____

Patient Name: Mr/Ms_____ SS#:_____

Address:_____ City:_____,_____ Zip:_____

Phone:_____ Birthday:_____

Primary:_____ Secondary:_____

Policy #:_____ Policy #:_____

Step 2

PATIENT TESTING FREQUENCY? ❑ 1x day ❑ 2x day ❑ 3x day ❑ 4x day ❑ Other _____ x day

SUPPLIES ORDERED: ❑ Blood Glucose Meter ❑ Lancet Device ❑ Test Strips ❑ Lancets ❑ Control Solution
❑ Syringes or ❑ Pentips Units_____Size_____

Step 3

***Medicare requires a reason** for high frequency testing which includes testing more than **1x day for NON-INSULIN (NIDDM)** treated OR more than **3x day for INSULIN (IDDM)** treated patients.

❑ Fluctuating Blood Sugar ❑ Hypertension ❑ Hypoglycemia
❑ To Maintain Control ❑ Brittle Diabetic ❑ Hyperglycemia
❑ Uncontrolled Diabetic ❑ Change of Medication
❑ Other_____

INSULIN TREATED? ❑ Yes ❑ No ICD-10 Code: ❑ E11.9 ❑ E11.65 ❑ E10.9 ❑ E10.65 ❑ Other_____

❑ 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 & has been trained to use ordered items. 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

Date of Patient's last Dr. visit:_____

Print Physician's Name:_____ Ph #:_____

Physician Signature:_____ Date:_____

NPI:_____ DEA:_____ City:_____, ST:_____

Accredited by
JCAHO