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:_____ Cell:_____ 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
- ✓ Meter
- ✓ Lancing Device
- ✓ Control Solution
- ✓ Alcohol Pads

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
- ❑ Fluctuating Blood Sugar
- ❑ Hypoglycemia
- ❑ Hyperglycemia
- ❑ Hypertension
- ❑ Obesity
- ❑ Other: _____

Is the patient treated with INSULIN ❑ Yes ❑ No Diag: ❑ E11.9 ❑ E11.65 ❑ E10.9 ❑ E10.65 ❑ _____

❑ 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