CERTIFICATE OF MEDICAL NECESSITY

To Contact Our Office Call: (678) 919-9128

Fax Completed Form To: 1-888-495-8205

PATIENT INFORMATION:

Patient Name: ____ Date of Birth: ________/_______/________

Address: ____ Phone: ____________________________

City: ____ State: ____________________ Zip: _____________________

Primary Insurance: _______________________________________ Member ID: ______________________________

ORDER DETAILS: Continuous Glucose Monitor (CGM) (Length of Need: Lifetime, unless specified otherwise)

☐ **K0554** Receiver for use with Therapeutic Continuous Glucose Monitor (1 Reader / 1095 Days)
☐ **K0553** Therapeutic CGM, Supplies & Accessories (1 Unit / 30 Days, 1 month of sensors and supplies)

DIAGNOSIS (ICD 10 Codes):
☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: ____________________________________

PRESCRIBED NUMBER OF GLUCOSE TESTS PER DAY: ____

CURRENT INSULIN REGIMEN:
☐ Insulin Pump ☐ Multiple Daily Injections - Times Per Day: _______________ ☐ Other: ________________

PHYSICIAN / TREATING PROVIDER'S INFORMATION:
By my signature, I certify that I am treating this patient under a comprehensive plan of care, have evaluated their medical condition and certify that the information provided is true and accurate, to the best of my knowledge.

____ _______________________________________

Physican's / Provider's Signature Date

____ _______________________________________

Physician's / Provider's Name (Printed) NPI

____ _______________________________________

Office Phone Number Office Fax Number

____

Address City State Zip

PLEASE ATTACH MOST RECENT OFFICE NOTES. THANK YOU.