



PHONE: 1.800.344.1550 FAX: 1.844.317.9377
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DIABETIC ORDER FORM

\*\*Please attach face sheet w/ patient demographics & insurance info\*\*

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: [ ] Male [ ] Female
Language Pref.: [ ] English [ ] Spanish [ ] Other: \_\_\_\_\_ Patient cannot accept deliveries on the following days?
Is the patient currently using insulin?: [ ] Yes [ ] No Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis ICD-10 Code: \_\_\_\_\_ Secondary Diagnosis ICD-10 Code: \_\_\_\_\_
\*Non-Specified Codes will not qualify for Primary Diagnosis

PRODUCTS

Table with 3 columns: Products, Testing Frequency, Total Quantity Dispensed (per 30 days). Rows include Prodigy Auto Code Glucometer, Prodigy Auto Code Testing Strips, Prodigy East Touch Lancets (30g), Prodigy Lancet Device, and Other.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Length of Need: \_\_\_\_\_ months

REFERRAL INFORMATION Ref #: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_
Office Address: \_\_\_\_\_ Email: \_\_\_\_\_
Phone: \_\_\_\_\_ Preferred Method of Contact? [ ] Phone [ ] Fax [ ] Email
Contact Person: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

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

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_