

****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
 Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ <small>*Non-Specified Codes will not qualify for Primary Diagnosis</small>	Secondary Diagnosis ICD-10 Code: _____
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PRODUCTS

Products	Testing Frequency	Total Quantity Dispensed (per 30 days)
<input type="checkbox"/> Prodigy Auto Code Glucometer	N/A	
<input type="checkbox"/> Prodigy Auto Code Testing Strips	_____ x per day	
<input type="checkbox"/> Prodigy East Touch Lancets (30g)	_____ x per day	
<input type="checkbox"/> Prodigy Lancet Device	_____ x per day	
<input type="checkbox"/> Other	_____ x per day	

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, 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: ____/____/____

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.