CHC SOLUTIONS, INC.

FAX: 1.877.299.7229
EMAIL: cgmorders@chcsolutions.com

CGM ORDER FORM

Please attach face sheet w/ patient demographics & insurance info as well as chart notes for visit(s) within the past six months*

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____ Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis ICD-10 Code:
☐ Z 79.4 ☐ Other:_____

Secondary Diagnosis ICD-10 Code:
☐ E 10.65 ☐ E 10.9 ☐ E 11.65 ☐ E 11.9 ☐ Other:_____

MEDICAL NECESSITY

☐ NEW USER ☐ CURRENT USER (Date received ___/___/_____) ☐ Current CGM:_____

Insulin Pump:
On an Insulin Pump? ☐ Yes ☐ No # of Injections:_____/day
HbA1c:_____ Date Last Tested:___/___/_____

Fluctuation of Blood Glucose Values:
Low_____mg/dL High_____mg/dL

Fasting Hyperglycemia:
_____mg/dL
BG Testing_____ /day

SUPPORTING CLINICAL INFORMATION

1. Does the patient have a diagnosis of insulin dependent diabetes mellitus or insulin treated gestational diabetes? ☐ Yes ☐ No
2. Does the patient's treatment regimen include at least three insulin injections per day or insulin pump therapy with frequent self-adjustment of insulin doses? (not applicable for gestational diabetes, Type 1 diabetes or rare forms of diabetes) ☐ Yes ☐ No ☐ N/A
3. Does the patient have documented blood glucose testing of four or more times per day? ☐ Yes ☐ No
4. Has the patient completed a comprehensive diabetes education program? ☐ Yes ☐ No
5. Has the patient been evaluated for their diabetes control in the last six months? ☐ Yes ☐ No
6. Does the patient have any of the following?
   - ☐ HbA1c of 7.0% or higher or less than 4.0%
   - ☐ Early morning fasting hyperglycemia
   - ☐ Hypoglycemic unawareness, nocturnal hypoglycemia or history of unexplained, severe hypoglycemic events (blood glucose < 50 mg/dL)
   - ☐ Unexplained fluctuations in daily pre-meal glucose levels
   - ☐ History of severe glycemic excursions
   - ☐ Recurrent episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels
   - ☐ Patient is pregnant and has poorly controlled diabetes or gestational diabetes
7. **For replacement receiver/reader only:** Is the receiver/reader malfunctioning, no longer under warranty or unable to be repaired? ☐ Yes ☐ No

PRODUCTS

Dexcom		Abbott
☐ Dexcom G6 Receiver, Qty 1	☐ Dexcom G7 Receiver, Qty 1	☐ Abbott FreeStyle Libre 2 Reader, Qty 1 ☐ Abbott FreeStyle Libre 2 Sensor, Qty 3
☐ Dexcom G6 Sensor, Qty 3	☐ Dexcom G7 Sensor, Qty 3	☐ Abbott FreeStyle Libre 3 Reader, Qty 1 ☐ Abbott FreeStyle Libre 3 Sensor, Qty 3
☐ Dexcom G6 Transmitter, Qty 1		☐ Abbott FreeStyle 14 Day Libre Sensor, Qty 3
		☐ Abbott FreeStyle Libre 2 Plus Sensor, 15 Day, Qty 2 (TANDEM PUMP USERS ONLY)

Length of need 12 months unless otherwise specified: ☐ Other:_____

REFERRAL INFORMATION

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Order 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.

Call **1.855.768.3680** or visit **www.chcsolutions.com** for additional information.