CHC SOLUTIONS, INC.

FAX: 1.877.299.7606
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

Currently on CGM Therapy? ☐ Yes ☐ No On an Insulin Pump? ☐ Yes ☐ No # of Insulin Injections:_____/day

HbA1c:_____ Date Last Tested:___/___/_____ Fasting Hyperglycemia:_____mg/dL # BG Testing_____/day

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

☐ NEW USER ☐ CURRENT USER (Date received ___/___/_____) ☐ REPLACEMENT OF DEXCOM RECEIVER

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. as 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 Dexcom receivers only:** Is the receiver malfunctioning, no longer under warranty or unable to be repaired? ☐ Yes ☐ No

PRODUCTS

Dexcom G6	Abbott FreeStyle Libre - Sensor Only	Abbott FreeStyle Libre 2
☐ Dexcom G6 Receiver Qty 1 Receiver, A9278, K0554		☐ Abbott FreeStyle Libre 2 Reader Qty 1 Transmitter, A9277, K0553
☐ Dexcom G6 Transmitter Qty 1 Transmitter, A9277, K0553	☐ Abbott FreeStyle Libre Sensor Qty 1, Change Sensor Every 14 Days, A9276, K0553	☐ Abbott FreeStyle Libre 2 Sensor Qty 1, Change Sensor Every 14 Days, A9276, K0553
☐ Dexcom G6 Sensor Qty 1, Change Sensor Every 10 Days, A9276, K0553		

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