



****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: <input type="checkbox"/> E 10.65 <input type="checkbox"/> E 10.9 <input type="checkbox"/> E 11.65 <input type="checkbox"/> E 11.9 Other: _____	Secondary Diagnosis ICD-10 Code: <input type="checkbox"/> Z 79.4 Other: _____
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Patient Insulin Regimen (Select one):

- Injects insulin ____ times per day
- Utilizing insulin pump - Model: _____ Date Received: ____/____/____
- Not on insulin
- Not on insulin - experienced Hypoglycemic event(s) (<54mg/dL)

PRODUCTS

Dexcom

Abbott

- Dexcom G7 Receiver, Qty 1
- Dexcom G7 Sensor 10 Day Wear, Qty 3
- Dexcom G7 Sensor 15 Day Wear, Qty 2

- Abbott FreeStyle Libre 3 Reader, Qty 1
- Abbott FreeStyle Libre 3 Plus Sensor, Qty 2

- Dexcom G6 Receiver, Qty 1
- Dexcom G6 Transmitter, Qty 1
- Dexcom G6 Sensor, Qty 3

- Abbott FreeStyle Libre 2 Reader, Qty 1
- Abbott FreeStyle Libre 2 Plus Sensor, Qty 2

OK to substitute with equivalent product: Yes No

Does the patient currently have a reader/receiver? No Yes, model: _____ Date Received: ____/____/____

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.