CHC SOLUTIONS, INC.

FAX: 1.855.255.6844
EMAIL: CloverOrders@chcsolutions.com

CLOVER HEALTH 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:

☐ E 10.65 ☐ E 10.9 ☐ E 11.65 ☐ E 11.9 Other:_____

Secondary Diagnosis ICD-10 Code:

☐ Z 79.4 Other:_____

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 **1.855.201.3724** or visit **www.chcsolutions.com** for additional information.