CHC SOLUTIONS, INC.

FAX: 1.855.255.6844
EMAIL: CloverOrders@chcsolutions.com

CLOVER HEALTH DIABETIC ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

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

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Is the patient currently using insulin?: ☐ Yes ☐ No

Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: _____	**ICD-10 Code:** _____
*Non-Specified Codes will not qualify for Primary Diagnosis	

PRODUCTS

Products	Testing Frequency	Total Quantity Dispensed (per 30 days)
☐ Prodigy Auto Code Glucometer	N/A	
☐ Prodigy Auto Code Testing Strips	_____x per day	
☐ Lancets (30g)	_____x per day	
☐ Prodigy Lancet Device	_____x per day	
☐ Other	_____x per day	

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: _____ 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.