Medical Service Company | MSC Diabetes
Division of Medical Service Company

CGM Fax Order Form

Sales Rep Name: _____
Phone #: _____
Fax #: _____

PATIENT INFORMATION

Patient Name: _____ **Date Prescribed:** ____/____/____

Date of Birth: ____/____/____ **Length of Need: 99 months (lifetime) OR** _____ **# of months)**

Home Phone/Cell #: _____ **Diagnosis (check box):**

Address: _____ Type 1 Diabetes: ☐ E10.9 ☐ E10.8 ☐ E10.65 ☐ E10.649

City: _____ **State:** _____ **Zip:** _____ Type 2 Diabetes: ☐ E11.9 ☐ E11.8 ☐ E11.65 ☐ E11.649

Email: _____ ☐ Other: _____

OTHER PATIENT INFORMATION

Patient is testing blood glucose _____ times a day.

Patient is insulin dependent? ☐ Yes ☐ No

If **Yes**, how many times is the patient injecting? _____

INSULIN SUPPLIES FOR TANDEM & MEDTRONIC

☐ Infusion Sets (____ units/3 months)

☐ Cartridges/Reservoirs (____ units/ 3 months)

☐ IV Prep/Barrier Wipes (150 each/3 months)

☐ Other items needed:

CONTINUOUS GLUCOSE MONITOR AND ALL RELATED SUPPLIES

☐ FREESTYLE LIBRE 3 READER
- ☐ FreeStyle Libre 3+ 15-Day Sensors (6 units/ 3 months)

☐ FREESTYLE LIBRE 2 READER
- ☐ FreeStyle Libre 2+ 15-Day Sensors, (6 units/ 3 months)

☐ DEXCOM G7 RECEIVER
- ☐ Dexcom G7 Sensors (9 units/ 3 months)

☐ CGM SUBSTITUTIONS PERMITTED

OTHER SUPPLIES

☐ True Metrix Test Strips (units based on times testing)

☐ Ultilet Classic Lancets (units based on times testing)

☐ True Metrix Glucometer

☐ Lancing Device (1 per 6 months)

☐ Other Items Needed: _____

MEDICARE CGM COVERAGE REQUIREMENTS TO INCLUDE IN CHART NOTES:

1. Patient has Type 1 or Type 2 diabetes.
2. Patient must be on insulin or has a history of multiple hypoglycemic episodes. **Please scan QR code for hypoglycemic episode payment criteria.**
3. Patient has had an appointment with their physician in the last 6 months pertaining to their diabetes.

ADDITIONAL NOTES:

Physician's Signature: _____ **Date:** ____/____/____

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____