MSC Diabetes
Division of Medical Service Company

Please fax completed form to 1-877-824-1411

Pump Supplies Fax Order Form

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

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

Address: _____

City/Zip: _____

Home Phone/Cell#: _____

Date of Birth: _____

Length of need: 99

Diagnosis (check box):

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

Type 2 Diabetes: ☐ E11.9 ☐ E11.8 ☐ E11.65 ☐ E11.649

☐ Other: _____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

OTHER PATIENT INFORMATION

Patient is testing blood glucose _____ times a day.

Patient is insulin dependent? ☐ Yes ☐ No

INSULIN SUPPLIES

☐ Infusion Sets/Pods (____ units/ 3 months)

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

☐ Cartridges/Reservoirs (____ units/ 3 months)

☐ Other items needed: _____

OMNIPOD

☐ Omnipod

Qty: _____

SIG: _____

Refills Allowed: _____

Medicare CGM Coverage Requirements to Include in Chart Notes:

1) ***Patient has Type 1 or Type 2 diabetes.***
2) ***Patient must be injecting insulin at least 3x/day and requires frequent adjustment.***
3) ***Patient has been seen by physician in the last 6 months.***
4) ***It is medically necessary for patient to have therapeutic CGM.***

ADDITIONAL NOTES: _____

_____

_____

_____

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

Physician's Printed Name: _____ Ph: _____ Fax: _____

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

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