MSC Diabetes
Division of Medical Service Company

Select Branch or Representative

CGM 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

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)

☐ **DEXCOM G6 RECEIVER**

☐ Dexcom G6 Sensors (3 units/ 3 months)

☐ Dexcom G6 Transmitter (1 unit/ 3 months)

OTHER SUPPLIES

☐ True Metrix Air 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: _____ Ph: _____ Fax: _____

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

Name of Agent Completing Form: _____

www.MedicalServiceCo.com

ePrescribe
Name: Medical Service Companies
NPI: 1972554939
NCPDP ID: 3626035

Scan to place an electronic order.

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