ARTHEON MEDICAL

FreeStyle Libre
Dexcom

○ E2103 Receiver (Monitor), dedicated, for use with therapeutic Continuous Glucose Monitor system - 1 unit Receiver

○ A4239- Supply allowance for therapeutic Continuous Glucose Monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service

EST. LENGTH OF NEED-(# OF MONTHS): ______

Only valid for 6 months per visit

PATIENT INFORMATION

Patient Last Name: ______ **Patient First Name:** ______

Date of Birth: ___ / ___ / ___ **Patient Address:** ______

City: ______ **State:** ___ **Zip:** ___

Phone Number: ___ – ___ – ___ **Patient Email:** ______

Primary Insurance Name: ______ **Member ID:** ______

Secondary Insurance Name: ______ **Member ID:** ______

MEDICAL NECESSITY

Currently on CGM Therapy? ○ Yes ○ No

Insulin Dependent? *(via injection or inhaled, no oral)* ○ Yes ○ No

# of Insulin Injections per day *(May be 1-2-3-4 or more per CMS LCD ID L33822)* ______ per day

Date of Last Visit (Must be within 6 months of this order- patient must also be seen every 6 months for resupply orders: ______

On insulin pump? ○ Yes ○ No

Diagnosis Code: ICD-10 Code: ○ E10.65 ○ E10.9 ○ E11.9 ○ Other ______

PHYSICIAN INFORMATION

Physician Last Name: ______ **Physician First Name:** ______

Phone Number: ___ – ___ – ___ **NPI #:** ______

Fax Number: ___ – ___ – ___

Do you E prescribe through one of the following platforms? If not, would you be interested in signing up at no cost for either one or both platforms?

☐ *Go Scripts* ☐ *Parachute Health* ○ *Yes* ○ *No*

This document serves as a Detailed Written Order and Statement of Medical Necessity for the above referenced patient for a Continuous Glucose Monitoring System and/or sensors, to be provided by an authorized supplier of services..

I certify that I am the physician identified above and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge. I have had a face to face visit with the patient in the past 6 months and I understand that moving forward the patient must be seen every 6 months to remain compliant for resupply orders.

****Please indicate the Make and Model of monitor/ receiver that is being ordered for patient****

☐ Freestyle Libre 14 Day (Sensor Refill) ☐ Freestyle Libre 2 (Reader kit & Sensors)

☐ Dexcom G7 (Reader kit Sensors) ☐ Freestyle Libre 3 (Reader kit & Sensors)

Signature: ______ **Date:** ______

Please send the completed form along with current (6 months) OV notes to supplier via secure email or fax: (813) 367- 1131