



Carolina Diabetic Supply Group, Inc.
PO Box 12734
New Bern, NC 28561
Phone (800) 575-2291 Fax (252) 633-4156

Attention: New Patient Dept.
Toll Free Fax: 866-633-4156

Referral: _____

Patient Information

Patient Name: _____ **Phone:** _____
 (First) (MI) (Last)
 Address: _____ City: _____ State: _____ ZIP: _____
 Birth Date: _____ Sex: Male / Female Social Security #: _____
 Alternate Contact: _____ Phone: _____
 Medicare Medicaid Other Insurance: _____ Insur. Phone: _____
 Policy #: _____ Group #: _____
 Insured (if different than patient): _____ DOB: _____ SS #: _____

Assignment of Benefits

I hereby authorize the release of any medical or other information necessary, for Carolina Diabetic Supply Group, Inc. to process my request for diabetic supplies and submit claims to my insurer. I also authorize payments of medical benefits to Carolina Diabetic Supply Group, Inc. If my insurance company sends the payments directly to me for any supplies furnished by Carolina Diabetic Supply Group, Inc., I will either forward all checks from my insurance company, or write a personal check to Carolina Diabetic Supply Group, Inc. I will notify Carolina Diabetic Supply Group, Inc. immediately of any change in my insurance coverage. I have received and understand Patient Bill of Rights, Home Safety Information, Privacy Notice and Medicare DMEPOS Supplier Standards. I have been instructed and understand the warranty coverage on the product I have received. I am also confirming that I have successfully completed training or am scheduled to begin training in the use of my glucose monitor and supplies. In addition, I am capable of using the test results to assure appropriate glycemic control.

Signature of patient or parent/guardian: _____ **Date:** _____

Physicians Order

Doctors Name: _____ NPI: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____

1. **Diabetes ICD-9 Diagnosis:** Type 1 – (Insulin Injection dependent) 250.01 250.03 Other _____
 Type 2 – (Pills, Diet and/or Insulin Injection treated) 250.00 250.02 Other _____
2. **Insulin Treated?** Yes No
3. **Test Frequency:** 1 x/day 2 x/day 3 x/day 4 x/day Other _____ x/day
4. **Supplies Ordered:** *Only mark items NOT approved*
 Glucose Meter Glucose Test Strips Lancets Control Solution Meter Battery Lancing Device
 Ketone Strips Syringes Pen Needles Alcohol Swabs Glucose Tabs
5. **Dispense Insulin Pump Supplies:** Insulin Pump Model: _____
Only mark items NOT approved
 Infusion Sets Syringes Type Reservoir Prep Wipes Batteries Transparent Dressing Piston Rods Adaptors
 Frequency of Change for Infusion Sets and Reservoirs Every 3 Days Every 2 Days Other _____
6. Last Date Seen ____/____/____
7. **Duration of Need** is 99 lifetime unless otherwise noted _____ Medicaid and Private Insurances are 12 months

Medicare Patients

8. Medicare allows for 1 x/day non-insulin treated or 3 x/day insulin treated testing. Documentation must be in the patient's medical record to support higher testing frequency. **Please provide supporting documentation:**
 Labile/Fluctuating blood sugars Hyperglycemia Hypoglycemia Uncontrolled blood sugars
 Hypertension Change in medication or dosage HbA1c Value _____
 Other _____

By signing below, I confirm that the above information is true, accurate, and completed to the best of my knowledge. I confirm that this patient has diabetes, is/was being treated by me and is able to use the ordered items. The medical records for the patient substantiate the prescribed testing frequency. The patient or caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. Per Medicare/Insurance requirements, I will maintain a copy of this order in the patient's medical records. I agree to provide copies of the supporting medical records as requested for Medicare/Insurance review.

Physician's signature _____ **Date** _____