

Continuous Glucose Monitoring (CGM) Order Form

PHONE: 718-436-6088 • FAX: 718-436-3649 • EMAIL: DMEORDERS@MEDARTS.NET

ADDRESS: 5504 13TH AVE BROOKLYN, NY 11219

PATIENT INFORMATION			
FIRST NAME:		LAST NAME:	
DOB:	GENDER:	HT:	WT:
ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE:		CELL PHONE:	E-MAIL:
EMERGENCY CONTACT:		RELATION:	PHONE:
INSURANCE INFORMATION			
PRIMARY INSURANCE NAME:		SECONDARY INSURANCE NAME:	
PRIMARY INSURANCE ID:		SECONDARY INSURANCE ID:	
MEDICAID ID:			
ORDER DETAIL			
☐ LIBRE 3 READER (Qty: 1)	☐ LIBRE 2 SENSOR (Qty: 2)	☐ DEXCOM G7 READER (Qty: 1)	
☐ LIBRE 3 SENSOR (Qty: 2)	☐ LIBRE 14 DAY SENSOR (Qty: 2)	☐ DEXCOM G7 SENSOR 10 DAY (Qty: 3)	
☐ LIBRE 3 PLUS SENSOR (Qty: 2)		☐ DEXCOM G7 SENSOR 15 DAY (Qty: 2)	
CLINICAL INFORMATION			
Diagnosis Code (select all that apply)			
☐ E10.9	☐ E11.65	☐ E10.65	
☐ E11.8	☐ E11.9	☐ Other _____	
INSULIN REGIMEN			
PATIENT IS ON:			
☐ INSULIN INJECTION(S)	INSULIN NAME: _____	DOSAGE: _____	
AND / OR	INSULIN NAME: _____	DOSAGE: _____	
☐ INSULIN PUMP	PUMP NAME: _____ (if applicable)		
IF NOT ON INSULIN BUT HAS HISTORY OF PROBLEMATIC HYPOGLYCEMIA (select only if applicable)			
Problematic hypoglycemia must document at least one of the following:			
☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite MULTIPLE attempts to adjust medication(s) and/or modify the diabetes treatment plan (provide detailed documentation)			
☐ A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia (provide detailed documentation)			
NOTE			
ALL CGM ORDERS MUST INCLUDE MOST RECENT MEDICAL RECORDS (WITHIN LAST 6 MONTHS) INDICATING PATIENT IS UNDER A COMPREHENSIVE PLAN OF CARE FOR THEIR DIABETES AND HAS HAD AN IN-PERSON OR TELEHEALTH VISIT TO EVALUATE THEIR DIABETES CONTROL			
CERTIFICATE OF MEDICAL NECESSITY			

I certify that the clinical information provided above is true and accurate to the best of my knowledge and the items ordered above are medically necessary for my patient. By signing below, I attest that I have no financial relationship with the DME supplier.

Physician Name: _____ NPI #: _____ Phone: _____

Address: _____ Fax #: _____

Physician Signature: _____ Date: _____

FAX FORM TO 718-436-3649 OR SEND ELECTRONIC PRESCRIPTION DIRECTLY FROM YOUR EMR SYSTEM OR FROM PARACHUTE HEALTH