Therapeutic Continuous Glucose Monitor (CGM)
Medicare Detailed Written Order

Please Fax to: (253) 212-1561
1800 SW 152ND St STE 205 BURIEN, WA 98166
P: (253) 244-9250

DME NorthWest

FreeStyle Libre
FLASH GLUCOSE MONITORING SYSTEM

Instructions

1. Complete all fields on this Detailed Written Order.
2. Use the Noridian November 2017 Physician Resource Letter (Continuous Glucose Monitors) to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier to provide a CGM system.

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

_____

Physician Information

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

Order Detail

Order Date: _____ / _____ / _____

K0554 (Receiver for use with Therapeutic CGM)	K0553 (Therapeutic CGM, Supplies & Accessories)
1 Reader/1095 Days Length of Need: Lifetime-unless specified otherwise: _____	1 Unit/30 Days (1 Unit = 1 month of sensors and supplies) Length of Need: Lifetime-unless specified otherwise: _____

Diagnosis (ICD10):

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Important Coverage Criteria:
The below conditions must be met for the insurances to provide coverage for these items: This should be supported by the patients' Medical Records.

- Patient currently checks their blood glucose levels 4 or more times per day.
- Patient currently injects insulin 3 or more times per day or is currently using an insulin pump.
- The patient's insulin treatment regimen requires frequent adjustments due to self-testing results.
- The patient has had a doctor visit to evaluate their diabetes control within the last 6 months.
- Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

By my signature below, I confirm that the patient has the medical condition(s) listed above and is being treated by me. The above information is true, accurate and complete to the best of my knowledge. I certify that the items/services listed above are medically necessary to treat this patient's condition and accurately reflect the treatment regimen I have prescribed. My medical records for this patient substantiate the prescribed treatment plan. I certify that my patient and/or caregiver are capable of using these products safely and effectively. Per Medicare, Medicaid and other insurance requirements, I will maintain a copy of this order in the patient's medical record. I agree to provide copies of all supporting medical records substantiating the medical necessity for the products ordered as requested for insurance review/audit purposes.

Physician Signature: _____ **Date:** _____