



CMN for Diabetic Testing Supplies

Patient Name: _____ D.O.B: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____

1. PERIOD OF MEDICAL NECESSITY:

A. Estimated length of need: _____

B. Dates from: _____

2. EQUIPMENT PRESCRIBED:

- Glucose Monitor
- Strips
- Lancets
- Alcohol Swabs
- Lancet Device
- Syringes, if necessary
- Batteries
- Control Solution

3. DIAGNOSIS : 250.00 250.01 other _____

4. Does the patient have insulin-treated diabetes? No Yes

5. How many times PER DAY should the patient test? _____

6. Is the device designed for home use rather than clinic use? Yes

SEVERITY OF CONDITION: _____ PROGNOSIS: _____

I, the undersigned, certify that the above equipment is medically necessary for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as 'convenience' equipment.

Physician: _____ NPI: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____ Fax: _____

SIGNATURE: _____ Date: _____