QUEST HEALTH SOLUTIONS

Tel: 1-800-993-9996
FAX: 866-422-5283

Dexcom
CONTINUOUS GLUCOSE MONITORING

PHYSICIAN'S AUTHORIZATION FOR DME

PATIENT INFORMATION

Name:	**Address:**	**DOB:**
Phone:	**Primary Insurance:** **Member ID:**	**Medicare ID:**
	Secondary Insurance:	**Member ID:**

Diagnosis Code:	**DX:**_____

MEDICAL RECORD REQUIREMENTS FOR CGM

Medical records should indicate: **(please check the following boxes)**

☐ **Beneficiary has diabetes mellitus, and**

☐ **Beneficiary is insulin treated with multiple (3 or more) daily injections of insulin, and**

☐ **Beneficiary's insulin regimen requires frequent adjustments on the basis of BGM or CGM testing results.**

Equipment to Prescribe:	-K0554- receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system (Dexcom reader) -K0553- supply allowance for therapeutic CGM, includes all supplies & accessories, 1 month supply (Dexcom sensors)
Length of Need:	Lifetime-unless specified otherwise

PLEASE COMPLETE AND RETURN WITH A COPY OF THE PATIENT'S LAST 2 OFFICE VISITS ASSOCIATED WITH THE REQUESTED PRODUCT, ACCORDING TO INSURANCE GUIDELINES.

PHYSICIAN INFORMATION	
Name:	**Fax:**
NPI:	**Phone:**

Signature:_____ **Date:**_____

I HAVE REVIEWED THE PRESCRIPTION ABOVE AND FOUND THE INFORMATION TO BE ACCURATE. I CERTIFY THE MEDICAL NECESSITY TO FACILITATE MANAGEMENT OF THIS PATIENT'S DIAGNOSIS. THIS PRESCRIPTION ACCURATELY REFLECTS THE PATIENT'S CONDITION, AND IS SUBSTANTIATED BY MEDICAL RECORDS.