suncare
Medical Corp

TOLL FREE FAX# 1-855-611-4082

CERTIFICATE OF MEDICAL NECESSITY FOR CONTINUOUS GLUCOSE MONITOR SUPPLIES

PATIENT NAME: **HIC#:**

PATIENT ADDRESS: **GENDER:**

PATIENT PHONE: **PATIENT DOB:**

ORDERING PRACTIONER: **TELEPHONE:**

ADDRESS: **PRACTIONER NPI:**

1 Please CHECK ALL that apply

(A) What is the patient's **Primary Diagnosis:**

- ☐ E10.9
- ☐ E11.9
- ☐ E10.65
- ☐ E11.8
- ☐ E11.39
- ☐ E11.9 ☐ *Other:* _____

(B) Patient Insulin use: ****If currently using insulin***

- Insulin? Yes ☐ No ☐
- Daily Injections: _____ per day
- Insulin Pump: ☐
- *Other:* _____

2 I Prescribe the following and have crossed out what I am (not) prescribing:

- ☐ Sensors
- ☐ Transmitter
- ☐ Receiver (1/5 yrs)
- ☐ Test Strips
- ☐ Lancets
- ☐ Control Solution
- ☐ Lancing Device
- ☐ Glucose Meter

***** Medical justification must be documented in the patient's medical record *****

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription and I certify that the above prescribed equipment is medically necessary and reasonable, and is consistent with the current standards of medical practice and treatment of this patient's condition. I will maintain an original, signed copy of this physician order in my medical records and make it available to Medicare, their authorized agents, or other insurer, if required.

3 Order Date: _____

4 Signature: _____

5 Length of Need: Lifetime - unless otherwise specified _____

6 Signature Date: _____

***If prescriber name is *different* than who is above section (1) please correct prescriber's name below and provide NPI**

Name: _____ **NPI:** _____ ***(NO SIGNATURE STAMPS PLEASE)***