family Medical Supply, Inc.

103 N. College St.
Mountain Home, AR 72653

Office (870) 424-3472
Toll Free (866) 326-4401

Per patient's consent, please complete order and fax to:

Fax (870) 424-3475

Physician's Order: Diabetic Testing Supplies and Training

Patient Name: ____

Home Phone:______________________ DOB: ________________________

*(Must check) **Diagnosis Codes:** (5-digit numbers please)

___ 250.01 (if insulin-dependent) ___ 250.00 (if NOT insulin-dependent) ___ Other: __________

*(Must check) **Frequency of Testing:**

___ 1 x Daily ___2 x Daily ___3 x Daily ___4 x Daily ___Other ____________________

Physician's Narrative: A **narrative** is required by Medicare if the frequency of testing prescribed is BID or greater for a non-insulin diabetic. Medicare will deny the claim unless the **narrative** is present **OR** a copy of the beneficiary's log is attached.

*(Must check) **Supplies requested:**

________ Blood Glucose Meter/Log Book ________ Testing Strips

________ Lancets ________ Lancing Device

________ Control Solution ________ Insulin Syringes
____1/2cc ____1 cc

I, the undersigned, certify that the above prescribed medical supplies are medically necessary as part of my treatment for this patient, and is documented in my patient files. In my opinion, the above prescribed supplies are reasonable and necessary for accepted standards of medical practice and treatment of this patients' condition.

*(Must sign) **Physician's Signature:** ______________________________

*(Must have) **Start Date:** ______________________________