L11520 Glucose Monitors

ALLSTATE DME LLC
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McAllen, TX 78504

Phone (956) 992-8866
FAX (956) 287-8586

Provider No. 6385310001

PHYSICIAN: _____

_____

_____

UPIN _____ **NPI** _____

Phone _____

PATIENT: _____

_____

_____

Phone _____

DOB _____

Policy: _____

Initial Date _____

Revised Date _____

Recertification

Length of Need : _____

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative
	E0607	GLUCOMETER
	A4258	LANCET DEVICE
	A4259	LANCETS
	A4253	TEST STRIPS

ADDITIONAL MEDICAL INFORMATION (circle one please)

1. Is the patient Insulin dependent? ☐ Y ☐ N
2. Is the patient's diabetes controlled? ☐ Y ☐ N
3. INJECTION FREQUENCY (Tests per day)? ☐ NONE ☐ 1X ☐ 2X ☐ 3X ☐ 4X / More
4. TESTING FREQUENCY (Tests per day)? ☐ 1X ☐ 2X ☐ 3X ☐ 4X / More

By signing below, I confirm that the patient has diabetes which is/was being treated by me. I maintain records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing. The patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control.

Dear Physician,
The following information was provided to our office as part of the order intake process. Please confirm that the information is correct. If the information is correct it needs to be inserted into the attached Written Order form. Any changes or corrections should also be inserted into the attached form. Once all sections of the Written Order are completed, please sign, date and fax the form back to our office. Thank you.

Clinician Signature _____ **Date** _____