



Physician's Order Form

INSTRUCTIONS: Please complete all sections to reflect the current regimen prescribed for your patient, sign and date below to confirm this ongoing course of treatment.

Patient Information		Physician Information	
Name:		Name:	
Address:		Contact:	
City, State, Zip Code		Address:	
Home Phone:	Mobile:	City, State, Zip Code	
HICN:	Date Of Birth:	Office Phone:	Fax:
Patient ID (for office use only):	Rep ID:	NPI #:	

ITEMS AND QUANTITIES NOT TO EXCEED THIS ORDER AND SUBJECT TO PATIENT'S ORDER, ACTUAL USE AND INSURER GUIDELINES

① → ____/____/____ - Most recent date this patient's diabetes control was evaluated & charted.

② → **START** date of Order ____/____/____

③ → **LENGTH** of Order: Lifetime or if other _____ (Specify length in months, weeks or days)

④ → **DIAGNOSIS:** 250.00 250.01 or if other ICD: _____

⑤ → **TREATMENT** with Insulin Injections: YES NO

⑥ → **TESTING REGIMEN** and Strip/Lancet quantity to be provided

- | | | |
|---|---|---|
| <input type="checkbox"/> 1x/day (100 strips & lancets/3 months) | <input type="checkbox"/> 2x/day (200 strips & lancets/3 months) | <input type="checkbox"/> 3x/day (300 strips & lancets/3 months) |
| <input type="checkbox"/> 4x/day (400 strips & lancets/3 months) | <input type="checkbox"/> 5x/day (450 strips & 500 lancets/3) | <input type="checkbox"/> 6x/day (550 strips & 600 lancets/3) |
| <input type="checkbox"/> 7x/day (650 strips & 700 lancets/3) | <input type="checkbox"/> 8x/day (750 strips & 800 lancets/3) | <input type="checkbox"/> Other ____ times per _____ |

⑦ → Is patient deaf, blind, and/or mentally incompetent? YES NO

If YES, please explain: _____

⑧ → **PRODUCT ORDER**

CROSS OUT (STRIKE THROUGH) EACH ITEM YOU DO NOT WISH TO AUTHORIZE/ORDER

- | | |
|--|---|
| ▶ 1 ea. Home Blood Glucose Testing Device (Meter) | ▶ Lancets per Testing Regimen and actual use |
| ▶ Test Strips/Cartridges per Testing Regimen and actual use | ▶ Spring Powered Lancet Device 1 every 6 months |
| ▶ Testing Device Replacement Batteries per mfg. requirements | ▶ Testing Device Control Solution per mfg. requirements |

⑨ → **EOCENE PATIENT MONITORING** YES NO

⑩ → **BY SIGNING BELOW**, I agree to maintain the original, signed copy of this document in my medical records. My medical records substantiate I was treating this patient under a comprehensive care plan for Diabetes Mellitus on the Start date (above) and that this patient (or caregiver) is able to use the items herein ordered to manage the patient's glycemic control. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

⇒ **SIGNATURE** _____ ⇒ **DATE** _____ ⇒ **NPI** _____
Ordering Physician's Signature and Date NPI required for validation

Physician Help Line: 1-800-385-1188 Fax: 1-800-859-4795

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