BLACKBURN'S

HAR-KEL INC. Medical Specialties a division of BLACKBURN'S

CGM ORDER FORM

Phone: 800-472-2440 Fax: 724-230-3705
Please contact Customer Service with any questions

Please complete all the information below and attach all patient demographic information

PATIENT

First Name: _____ Last Name: _____ Male: ☐ Female: ☐

Address: _____ DOB: _____ HGT: _____ WGT: _____

City: _____ State: ___ Zip: _____ Phone: _____ Alternate Phone: _____

Email: _____ Patient's Preferred Language: ☐ English ☐ Spanish Other: _____

Responsible / Emergency Contact: _____ Emergency Contact Phone: _____

Is the patient being seen by a Home Health Agency? ☐ Yes ☐ No Has the patient been notified of this order? ☐ Yes ☐ No

INS

Primary Insurance: _____ Policy ID # _____ Group # _____ Phone: _____

Secondary Insurance: _____ Policy ID # _____ Group # _____ Phone: _____

Diagnosis

Primary ICD-10 Diagnosis Code (required):

☐ E 10.65 ☐ E 10.9 ☐ E 11.65 ☐ E 11.9 Other: _____

Secondary ICD-10 Diagnosis Code (required):

☐ Z 79.4 Other: _____

Medical Necessity

Currently on CGM Therapy? ☐ Yes ☐ No Date Received: _____

Currently on an Insulin Pump? ☐ Yes ☐ No Number of Insulin Injections: _____ / day

HbA1C: _____ Date last tested: _____

Fluctuation of Blood Glucose Values: Low: _____ mg/dL High: _____ mg/dL

Supporting Clinical Indications (Patient must meet all criteria 1 thru 5)

☐ 1. Patient has diabetes mellitus.

☐ 2. The prescribing practitioner has concluded that the beneficiary has sufficient training on CGM.

☐ 3. CGM is prescribed in accordance with FDA indications for use.

4. The beneficiary for whom CGM is prescribed meets at least one of the criteria below. *Check box below that applies*:

☐ a. Beneficiary is insulin treated. Number of insulin injections _____ / day, **OR**

b. Beneficiary has history of problematic hypoglycemia (*select box below*)

☐ More than 1 LEVEL 2 Hypoglycemic events (<54 mg/dl) despite changes to medication or treatment plan, **OR**

☐ History of 1 Level 3 Hypoglycemic event (<54 mg/dl) characterized by altered mental / physical state.

☐ 5. Within 6 months prior to ordering CGM the treating practitioner has had an in-person or Medicare approved telehealth visit. Date of last visit: _____

Dispensing (Select the desired CGM model listed below)

Abbott Freestyle LIBRE 2 ☐ or 2+ ☐	Abbott Freestyle LIBRE 3 ☐ or 3+ ☐	Dexcom G7
LIBRE 2 or 2+ Reader (1 Unit) Qty: ____	LIBRE 3 or 3+ Reader (1 Unit) Qty: ____	Dexcom G7 Receiver Qty: ____
LIBRE 2 or 2+ Sensor (1 Unit) Qty: ____	LIBRE 3 or 3+ Sensor (1 Unit) Qty: ____	Dexcom G7 Sensors / Transmitter Qty: ____

REFERRAL INFORMATION

Office Name: _____ Phone: _____

Address: _____ Fax: _____

Contact: _____ Email: _____

How would you prefer to be contacted: ☐ Phone ☐ Fax ☐ Email

BY SIGNING BELOW, I CERTIFY that I am the clinician identified in this section and AUTHORIZE *the use of this document as an order.*
I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed and dated copy of this order in my medical records.

Ordering Clinician or Licensed Prescriber: (Please Print - Stamps not permitted) _____

Signature: _____ Date: _____ MD# _____ NPI: _____

PRESCRIPTION VALID FOR: **Order Date**: _____ **Start Date**: _____ **Number of Refills**: _____ **Length of Need (Months)**: _____