Diabetes Care Form

Please fax completed forms to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com** and save a copy in the patient's medical record. If the form is filled out by an office or clinical support staff member, it must be routed back to the provider for follow-up and sign off.

Patient Name: _____ DOB: _____ ID#: _____

Date Vitals Collected: ___/___/____ Blood Pressure: ____/_____

Diabetic Labs Completed in 2026		
Hemoglobin A1c Testing (HbA1c) **Date**: __ /__ /_____ **Result**: _____ Glucose Management Indicator Testing (GMI) **Date:** __/__/____ **Result:** _____	Estimated Glomerular Filtration Rate (eGFR) **Date**: __ /__ /_____ **Result**: _____	Urine Creatinine Test **Date**: __ /__ /____ **Result**: _____ Urine Albumin Test **Date**: __ /__ /_____ **Result**: _____ Urine Albumin-Creatinine Ratio (uACR) **Date**: __ /__ /_____ **Result**: _____

Retinal or Dilated Eye Exam Completed in 2025 (negative results only) or 2026 (positive or negative results)
Date Exam Completed: _____ / _____ / _____ ☐ **Negative for Retinopathy; Normal Retina** ☐ **Positive for Retinopathy** ☐ **Bilateral Eye Enucleation (anytime in member's history)** **Place of Service: _____** **Phone: _____ Fax: _____** **Eye Care Professional Name and Credentials (Print): _____**

Provider Signature and Credentials: _____ Date: ____ /____ /_____

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