

Diabetes Exclusion Form

Member Name: _____

Member ID#: _____

Date of Birth: _____

This member meets the criteria below:

- Member has been diagnosed with and/or treated for one or more of the following conditions
(please check all that apply):
- Polycystic Ovaries (any time in the member's history)
 - Gestational or steroid-induced diabetes (current year or year prior)
- Member does not have diabetes (current year or year prior)
- Member is being treated for diabetes

Please attach all applicable medical record documentation for this year and the year prior. Two years of medical record documentation, showing the member is not diabetic, is required to exclude the member from the diabetic population.

Provider Signature: _____

Date: _____

Please fax the completed form to 313-202-0006.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at 313-324-3700 if you have any questions.