HLMS HEALTHY LIVING MEDICAL SUPPLY

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For online prescriptions: myhlms.com/providers

Diabetic Testing Supply Prescription

Referred by:	Medications from Pharmacy: YES ☐ NO ☐	
Name:	Birthdate:	Sex: Male ☐ Female ☐
Address:	City:	State: MI Zip:
Email:	Cell:	Other Phone:

Insurance:

Meridian Health Plan ID:	HMO Plan:
Medicaid ID:	Policy ID:

Duration of Need:
☐ 12 months ☐ Other: _____ (Default is 12 months if nothing is marked.)

Diagnosis Code:
Type 1 = ☐ E10.9 (no complication) ☐ E10._____ (list additional numbers to specify complications)
Type 2 = ☐ E11.9 (no complication) ☐ E11._____ (list additional numbers to specify complications)
Other: _____ Gestational = _____ Due Date: _____
Is patient treated with **insulin**? YES ☐ NO ☐ If yes, are they using an insulin pump? YES ☐ NO ☐

Diabetes Testing Supplies: Glucose Monitor: HAS / NEEDS * *(circle one)* ←

☐ Test Strips ☐ Lancets ☐ Alcohol Pads ☐ Syringes: _____vol_____G_____mm QTY____
☐ Control Solution ☐ Other: _____ ☐ Pen Needles _____G _____mm QTY_____

Recommended Testing Frequency:

☐	1 time/day = up to 50 test strips/100 lancets/mo	☐	4 times/day = up to 150 test strips/200 lancets/mo
☐	2 times/day = up to 100 test strips/100 lancets/mo	☐	5 times/day = up to 175 test strips/200 lancets/mo
☐	3 times/day = up to 105 test strips/100 lancets/mo	☐	6 times/day = up to 200 test strips/200 lancets/mo
		☐	Other: _____ times/day Qty: _____

Please note reason for testing more than 6 times per day: _____

Physician Information:

Physician Name:		
Physician Signature:		Date:
Address:	DEA:	NPI:
City:	Email:	
State: Zip:	Phone:	Fax: