

Diabetic Testing Supply Prescription

For online prescriptions: myhlms.com/providers

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: