AdaptHealth Patient Care Solutions Inc.

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FREESTYLE LIBRE PRODUCT ORDER FORM

INTERNAL USE
Rep # _____
Ref # _____
Tracking ID # _____

PLEASE FILL IN ALL FIELDS WITH THE REQUIRED NECESSARY INFORMATION FOR YOUR ORDER TO BE PROCESSED

PATIENT

First Name _____ Last Name _____ ❑ M ❑ F DOB _____
Address _____ Phone _____ Alternate Phone _____
City _____ State _____ Zip _____ Email _____
Length of Need – (Lifetime unless otherwise indicated) _____ Months **DISPENSE:** ❑ 30 day supply ❑ 90 day supply **# OF REFILLS:** _____
Patient Height: _____ Patient Weight: _____

INS

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

DIAGNOSIS INFORMATION

STATEMENT OF MEDICAL NECESSITY

Currently on CGM Therapy? ❑ Yes ❑ No
On an insulin pump? ❑ Yes ❑ No
HbA1c _____
Multiple Daily Injections _____
Fasting Hyperglycemia: _____ mg/dL
Fluctuation of blood glucose values:
Low _____ mg/dL High _____ mg/dL
SMBG _____ per day

DIAGNOSIS CODE/ICD-10 CODE

INDICATE SPECIFIC DIAGNOSIS CODE for patient condition. Unspecified diagnosis codes are not accepted. _____

SUPPORTING CLINICAL INDICATIONS

❑ A. Patient administers 3+ injections per day
❑ B. Patient self checks BG 4+ times per day
❑ C. Patient's insulin treatment requires frequent adjustment by patient on the basis of BGM or CGM testing results.
❑ D. Within 6 months prior to ordering CGM, patient had in-person visit with treating practitioner to confirm that patient is diabetic and meets A-D above and to evaluate patient's diabetes control. **LAST OFFICE VISIT:** _____
❑ E. Patient is motivated and knowledgeable to use CGM, and adheres to a diabetes treatment plan.

When submitting this form, please include Chart Notes/Medical Records that substantiate the above clinical indicators, as well as notes from the patient's last visit, indicating Diabetic therapy was discussed.

DISPENSING

DESCRIPTION		QTY
❑ **Freestyle Libre Receiver**	1 Unit A9278, K0554	
❑ **Freestyle Libre Sensor**	1 unit A9276, K0553	

DOCTOR

Physician	NPI #	Email	Physician	NPI #	Email
❑ _____	# _____	_____	❑ _____	# _____	_____
❑ _____	# _____	_____	❑ _____	# _____	_____
❑ _____	# _____	_____	❑ _____	# _____	_____

Address: _____ Phone: _____ Fax: _____ Email: _____

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge.

X Physician Signature _____ (Signature and Date stamps are not acceptable.)
Physician Name _____
X Date _____ (Signature and Date stamps are not acceptable.)