

Detailed Written Order



Instructions

1. Complete all fields on this Detailed Written Order.
2. Use the Noridian November 2017 Physician Resource Letter (Continuous Glucose Monitors) to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier that provides the FreeStyle Libre 2 system

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

→ Primary Insurance: _____ → Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

Physician Information

Physician Name: _____ Phone: _____

→ NPI: _____ Fax: _____

Address: _____

Order Detail

Order Date: _____

E2103 - FreeStyle Libre 2 - Reader 1 Reader/1095 Days Length of Need: Lifetime - unless specified otherwise:	A4239 - FreeStyle Libre 2 - Sensors 1 Unit/30 Days (1 Unit = 1 month of sensors and supplies) Length of Need: Lifetime - unless specified otherwise:
→ Diagnosis (ICD10): <input type="checkbox"/> E10.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> E10.65 <input type="checkbox"/> E11.8 <input type="checkbox"/> E11.9 <input type="checkbox"/> Other: _____	
→ Prescribed Number of Glucose Tests Per Day: _____	
→ Current Insulin Regimen: <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Multiple Daily Injections - Number Per Day: _____ <input type="checkbox"/> Other: _____	

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ Date: _____

It is ultimately the responsibility of the healthcare professional/persons associated with the patient's care to determine and document the appropriate diagnosis(es) and code(s) for the patient's condition. Abbott does not guarantee that the use of any information provided in this form will result in coverage or payment by any third-party payer. Each healthcare provider is ultimately responsible for verifying codes, coverage, and payment policies used to ensure that they are accurate for the services and items provided.

Fax Orders: 866-984-2565