DETAILED WRITTEN ORDER

◯ E2103 **Receiver (Monitor), dedicated, for use with therapeutic Continuous Glucose Monitor system - 1 unit Dexcom Receiver**

◯ A4239 **Supply allowance for therapeutic Continuous Glucose Monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service**

EST. LENGTH OF NEED (# OF MONTHS): _____ **ORDER DATE:** _____

PATIENT INFORMATION

Patient Last Name: **Patient First Name:**

Date of Birth: / / **Patient Address:**

City: **State:** **Zip:**

Phone Number: – – **Dexcom Account #:**

Primary Insurance Name: **Member ID:**

Secondary Insurance Name: **Member ID:**

PHYSICIAN INFORMATION

Physician Last Name: **Physician First Name:**

Phone Number: – – **Hospital/Clinic:**

Fax Number: – – **Hospital/Clinic Address:**

City: **State:** **Zip:**

NPI #:

STATEMENT OF MEDICAL NECESSITY

Currently on CGM Therapy? ◯ Yes ◯ No **#SMBG** _____ **per day** **# Multiple Daily Injections per day** _____

Date of Last Visit (Must be within 6 months of this order): / / **On insulin pump?** ◯ Yes ◯ No

Diagnosis Code: ICD-10 Code: ◯ E10.65 ◯ E10.9 ◯ E11.9 ◯ Other _____

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring System, Dexcom Sensors, Dexcom Replacement Transmitter or Dexcom Replacement Receiver, and all associated diabetes supplies to be provided by Dexcom or an authorized distributor.

I certify that I am the physician identified on 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.

Signature: **Date:** / /

PLEASE FAX TO: 866-984-2565