Certificate of Medical Necessity

Fax: (978)849-6706

☐ New Order ☐ Refill ☐ Change

NEW ENGLAND HOME MEDICAL EQUIPMENT

Patient Name:_____ DOB:_____ ID:_____
Sex:_____ SS#:_____ Phone:_____ Patient Allergies:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Primary Insurance:_____ Group #:_____ Ins ID#:_____ Ins. Tel #:_____
Secondary Ins:_____ Group #:_____ Ins ID#:_____ Ins. Tel #:_____

****PLEASE DISPENSE A 90 DAY SUPPLY OF THE FOLLOWING ITEMS AT THE PATIENT'S REQUEST.**
BE SURE TO SELECT A REFILL OPTION FOR EACH PRESCRIBED ITEM**

ICD 10 DIAGNOSIS: _____ **SECONDARY ICD-10 DIAGNOSIS: _____**

INSULIN PUMP SUPPLIES: ► Insulin Infusion Pump (E0784) Model:_____

► Infusion Sets/ Pods (A4230, A4221, A9274, A9900 U3)
Type:_____
► Dispense infusion sets/pods according to frequency that patient changes infusion sets/pods: Every_____day(s)
•Every 3 days = #30 per 90 days •Every 2 days = #50 per 90 days •Every day = #90 per 90 days •Other: _____
► Reservoirs/Cartridges (A4232, K0552, A9900 U4)
► Dispense as directed. Refills: 1 year unless noted [ ]
Other:_____

CONTINUOUS GLUCOSE MONITORING SUPPLIES: A9278= 1/365 days • A9277= 2/365 days • A9276= 365/365 days

► CGMS **System** (A9277, A9278): ☐ Dexcom G4/G5 System ☐ Medtronic Enlite System ☐ Medtronic Guardian 3 System
► CGMS **Sensors** (A9276): ☐ Dexcom G4/G5 Sensors ☐ Medtronic Enlite Sensors ☐ Medtronic Guardian 3 Sensors
Dispense as directed. Refills: 1 year unless noted ☐ Other:_____

PATIENT INFORMATION: Medicare requires the external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple patients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetes educators and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy. Continued coverage of an external insulin pump and supplies requires that the patient be seen and evaluated by the treating physician at least every 3 months.

- Do you, as the prescribing healthcare provider, meet these requirements? ☐ Yes ☐ No
- Has your patient completed a comprehensive diabetes education program? ☐ Yes ☐ No
- Has your patient been on a program of multiple daily injections of insulin (at least 3 per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump? ☐ Yes ☐ No
- Has your patient had documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump? ☐ Yes ☐ No

Additionally, your patient must meet one or more of the following criteria while on the multiple injection regimen:

1. Glycosylated hemoglobin level (HbA1c) > 7% ☐ Yes ☐ No
2. Documented history of recurring hypoglycemia ☐ Yes ☐ No
3. Wide fluctuations in blood glucose before mealtime ☐ Yes ☐ No
4. Dawn phenomenon with fasting blood sugars frequently above 200 mg/dL ☐ Yes ☐ No
5. Documented history of severe glycemic excursions ☐ Yes ☐ No

PHYSICIAN INFORMATION: Physician Name:_____, MD
NPI :_____ Phone:_____ Fax:_____
Address_____ City:_____ State:_____ Zip Code:_____
CLIENT SINCE:_____ ORIGINAL DOCUMENT REQUEST/RE-REQUEST DATE:_____

My signature below denotes to the best of my knowledge the patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use and needed by the patient for controlling diabetes. **I hereby certify the medical necessity of these items for this patient.**

Physician Signature: _____ Date: _____