

To expedite processing, please fill out all areas. Incomplete forms will be returned.

I am referring _____
for medically necessary outpatient diabetes self-management training and other additional services as indicated below.

1° Ins: _____ Member ID # _____

2° Ins: _____ Member ID # _____

Insurance Customer Service Phone #: (or FAX insurance card with phone #'s visible)

Phone H _____ W _____

C _____ O _____

Address _____

City/State/Zip _____

SSN _____

Date of Birth _____ Female Male

- Check here for patients with special needs: Language Limitations Vision Hearing Physical Cognitive Impairment
 Other: _____

The following information is required for reimbursement by insurance companies: Physician diagnosis, ICD code, medical conditions and Plan of Care below. Please send recent labs pertinent for patient eligibility and outcomes monitoring. Check below all that apply:

***Physician's Diagnosis**

***Medical Conditions**

***Complications/Co morbidities**

- Type 1 DM controlled uncontrolled
- Type 2 DM controlled uncontrolled
- Gestational DM
- Non-dialysis Kidney Disease (Chronic Kidney Insufficiency)
- Post-Transplant Kidney Disease (within 36 months)
- Metabolic Syndrome
- Pre-Diabetes
- Other _____

- Newly diagnosed
- New to insulin
- New to oral anti-diabetes agents
- Severe hypo- or hyperglycemia in the past year requiring ER visit or hospitalization
- Elevated A1C
- Other _____

- Dyslipidemia
- Retinopathy
- Nephropathy
- Neuropathy
- Hypertension
- Renal Disease
- Non-healing wound
- Obesity
- Other _____

ICD-9 Code: _____ Last A1C result _____ % Date _____

Check Training Medically Necessary: Individual **DIABETES SELF MANAGEMENT TRAINING (DSMT)**

Individual **MEDICAL NUTRITION THERAPY (MNT)**

BOTH

DSMT All content areas, as appropriate or select below:

- Diabetes as disease process management or gestational diabetes management
- Prevent, detect and treat acute complications
- Nutrition Management
Dietitian to will determine an individual Meal Plan unless otherwise noted: _____ kcal/day
- Monitoring diabetes
- Goal setting, problem solving
- Preconception/pregnancy
- Physical activity
- Emotional aspects of Diabetes
- Prevent, detect and treat chronic complications
- Medications

Medicare: 3 hours initial MNT in the first calendar year and every year after two hours follow-up MNT. More hours available for change in medical condition, treatment and /or diagnosis.

Check Type of MNT and/or additional hours requested:

- Initial MNT Annual follow-up MNT
- Additional MNT services in the same calendar year as requested by RD for additional hours: _____

Please specify change in medical condition, treatment and /or diagnosis:

In case of hypoglycemia during class, give 15 grams of quick-acting carbohydrate and monitor blood glucose until resolved

CURRENT DIABETES MEDICATIONS: check if patient needs immediate injection administration instruction _____

Oral: _____

Insulin: _____ units/mcg of _____ to be taken

_____ units/mcg of _____ to be taken

_____ units/mcg of _____ to be taken

Patient now uses: Pen Needle Pump

Patient Behavior Goals/Plan of Care

Physician Signature _____ Physician's NPI #: _____ Date _____
(Physician Printed Name): _____ Phone _____ Fax _____

FAX completed form to (210) 733-6202. For questions, call (210) 733-0200