Performance™ Home Medical

phone: 866.687.4463 fax: 877.414.2727

Continuous Glucose Monitoring Order Form

Patient Name:	**Sex: M ☐ F ☐**	**DOB: / /**
Street Address:	**Apt. #:**	**Home Phone #:**
City:	**State:**	**Zip Code:**
Insurance Policy:	**Policy ID:**	**Today's Date: / /**

Continuous Glucose Monitoring System Prescription Form

1. The patient has a diagnosis of Diabetes Mellitus (Please include all relevant ICD-10 codes below):

- ☐ E10.65 – Type 1 Diabetes Mellitus with hyperglycemia
- ☐ E10.9 – Type 1 Diabetes Mellitus without complications
- ☐ E11.65 – Type 2 Diabetes Mellitus with hyperglycemia
- ☐ E11.8 – Type 2 Diabetes Mellitus with unspecified complications
- ☐ E11.9 – Type 2 Diabetes Mellitus without complications
- ☐ Other:

2. Please provide clinical notes with your order. Medical records must include the following details:

- ☐ Patient has a diagnosis of Diabetes Mellitus that is supported by relevant ICD-10 codes
- ☐ Patient demonstrates compliance with healthcare provider's ordered diabetic treatment plan
- ☐ Patient receives insulin via injections (at least three times/day) or via continuous administration (insulin pump)
- ☐ Patient required to regularly adjust insulin treatment regimen based upon blood glucose readings

Please select the needed items below and provide any additional details related to the treatment regimen:

☐	CGM Reader	1 device
☐	CGM Sensors	7 sensors/90 day supply (Freestlye Libre) 9 sensors/90 day supply (Dexcom)
☐	CGM Transmitter	1 device/90 day supply
☐	Other:	Please specify details of order for additional item(s):

Length of Need: 99 (Lifetime) unless otherwise specified:

Please include clinical notes from the last two office visits with order.
Please indicate the date of the patient's last office visit: / /

By signing this, you agree to the following:
The treating provider hereby confirms that the patient's diabetic condition warrants the need for Continuous Glucose Monitoring (CGM) as evidenced by the ICD-10 code(s) selected in Section 1 and clinical notes supporting the listed criteria in Section 2.

The treating provider hereby confirms that he/she is treating the above patient under a comprehensive plan of care for Diabetes Mellitus. The provider has met with the patient within six months prior to ordering CGM and will continue to meet with the patient every six months from the time the initial order was written.

Physician Information

Physician Name:		
Physician Signature:		
Phone Number:	**NPI:**	**Date: / /**