MISSION MEDICAL SUPPLY

CERTIFICATE OF MEDICAL NECESSITY

PHYSICIAN CERTIFICATION OF DIABETICS SUPPLIES PRESCRIPTION FORM

SAN DIEGO: 4444 EL CAJON BLVD STE. 3 - SAN DIEGO, CA. 92115 - TEL: 619-229-9597 - FAX: 619-229-9594
HOUSTON: 10515 BELLAIRE BLVD STE. M - HOUSTON, TX. 77072 - TEL: 281-933-3902 - FAX: 281-933-3949

Today's Date: PHYSICIAN NAME:

NPI NO.: DEA NO.: MEDICARE/MEDICAID NO.

PHYSICIAN ADDRESS: CITY: STATE: ZIP:

PHYSICIAN PHONE NO. PHYSICIAN FAX NO.

MEMBER INFORMATION

FIRST NAME: LAST NAME: INITIAL:

PHYSICAL ADDRESS: CITY: STATE: ZIP:

HOME PHONE: CELL PHONE: ALT. PHONE:

DATE OF BIRTH: HEIGHT: (FT) WEIGHT: (LBS) INSURANCE NAME:

MEDICARE MEDICAL POLICY NO:

PHYSICIAN SECTION: (Please complete all sections to reflect the current treatment prescribed for your patient, and fax it back to us)

STEP 1

Is the patient treated with insulin? ¨ YES ☐ NO ☐

STEP 2

Select ICD-10 Diagnosis Code

BELOW ARE SOME COMMON ICD-10 CODES THAT ARE DIAGNOSED AND BILLED FOR WITH THE HOME GLUCOSE MONITORS AND TESTING SUPPLIES. THIS IS NOT AN ALL-INCLUSIVE LIST; PLEASE SELECT OR WRITE IN THE DIAGNOSIS CODE THAT IS MOST APPROPRIATE FOR THE PATIENT.

☐ E10.65 Type 1 diabetes mellitus with hyperglycemia
☐ E10.9 Type 1 diabetes mellitus without complications
☐ E11.65 Type 2 diabetes mellitus with hyperglycemia
☐ E11.9 Type 2 diabetes mellitus without complications
☐ Other Diagnosis code:_____ *RANGE OF ICD-10 CODES: E08.00 - E13.9*

STEP 3

Patient's Testing Frequency:

☐ 1X/DAY ☐ 2X/DAY ☐ 3X/DAY ☐ 4X/DAY ☐ 5X/DAY ☐ OTHER: _____

Corresponding number of strips & lancets ordered for a 90 day period:
1x/day =100 2x/day =200 3x/day =300 4x/day =400 5x/day =450 6x/day =550 7x/day =650 8x/day =750 9x/day =850 10x/day =900

Diabetic Supplies Ordered/Prescribed: (cross out items not ordered)

Test Strips	Lancets	Control Solution	Lancing Device	Battery(ies)	Glucose Meter	Alcohol Pads
		1 PER 3 MONTHS	1 PER 6 MONTHS	1 PK PER 6 MONTHS	1 PER 5 YEARS	

Order Duration: Number of refills is 99x (lifetime), unless otherwise specified_____

PHYSICIAN SIGNATURE DATE

Please fax ORDER form to: SAN DIEGO FAX: 619-229-9594 or HOUSTON FAX: 281-933-3949