



Diabetes Self Management Training Medical Necessity Form
Complete and FAX BACK to 575-1060 THANK YOU

Patient's Last Name	First Name	Middle	:	Medicare HICN #
Address		Home Number	Work Number	

Diagnosis: *(Please fax recent labs)*

- | | |
|--|--|
| <input type="checkbox"/> Type 1 controlled | <input type="checkbox"/> Type 1 uncontrolled |
| <input type="checkbox"/> Type 2 controlled | <input type="checkbox"/> Type 2 uncontrolled |
| <input type="checkbox"/> Other: _____ | |

Diagnostic Criteria for Medicare to cover Diabetes education (check one):

- fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; OR
- a two-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; OR
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Complications/Comorbidities: *(Check all that apply)*

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Retinopathy |
| <input type="checkbox"/> Non Healing wound | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Mental/Affective Disorder | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Nephropathy |
| <input type="checkbox"/> CHD | |
| Other: _____ | |

Desired Outcomes

Evidence based: A1C < 7.0 B/P < 130/80 LDL < 100mg/dL

- Other _____

Diabetes Self Management Training:

(Check type of education services being ordered)

- Initial training including individual assessment and group education, total 10 hours**

- Other _____

- Patient has special need(s) that prevent him/her from participating in a group setting and require him/her to receive **individual** instruction (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cognitive Impairment |
| <input type="checkbox"/> Language Limitations | |
| <input type="checkbox"/> Other: _____ | |

Secondary Diagnosis Code related to special needs:

Physicians Issues/Concerns:

Clinical/Lab Results (enclose or indicate) :

A1C _____ B/P _____ LDL _____

- Other _____

Follow-up training (2 hours) is also available for out-of-control diabetic patients 12 months post initial training who meet specific criteria. Please let us know if your patient needs follow up training.

Signature:

Date

Provider Name, Address, and Phone Number: