Eden MEDICAL SUPPLY

800.838.3560
866.292.6645

# CGM DETAILED WRITTEN ORDER

## Patient Information

Name:
Date of Birth:
Phone Number:
Address:

Insurance ID:
Insurance Name:
Gender:

## Physician Information

Name:
NPI:
Address:

Phone:
Fax:

Email:

## Equipment to Prescribe

- K0554 / E2103 – FreeStyle Libre Reader, 1 reader / 1095 Days
- K0553 / A4239 – FreeStyle Libre Sensors, 1 month supply

Length of Need: Lifetime – unless otherwise specified here: _____

## Statement of Medical Necessity (please complete 1-5)

### ① Diagnosis

- □ E11.9
- □ E10.9
- □ E11.8
- □ E10.65
- □ E11.65
- □ Other: _____

### ② Insulin Regimen

- □ Insulin Pump
- □ Injections or Inhaler – # of administrations: _____
- □ Other: _____

### ③ Please send medical records to support medical necessity.

*I certify that I am the physician identified in the above section and I certify that information contained in this document reflects the patient's condition and is accurate to the best of my knowledge.*

### ④ Physician Signature: _____

### ⑤ Order Date: _____