Eden MEDICAL SUPPLY

800.838.3560
866.598.3366

CGM DETAILED WRITTEN ORDER

Patient Information

Name:
Date of Birth:
Phone Number:
Address:

Insurance ID:
Insurance Name:
Gender:

Physician Information

Name:
Phone:
Address:

NPI:
Fax:

Equipment to Prescribe

- **E2103** – Non-adjunctive non-implanted continuous glucose monitor, 1 reader/1095 Days
- **A4239** – Supply allowance for non-adjunctive non-implanted CGM, up to 90 day 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 **Patient meets at least one of the following criteria:**

☐ Patient is insulin-treated
☐ Patient has had a recurrent level 2 or one level 3 hypoglycemic event

③ **Attach medical records to support the above 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**: _____