PHYSICIAN ORDERS—DIABETES

Transmit by Email: _____
Fax: (_____) _____-_____

ABC Plus
AMERICA'S Best Care PLUS, INC.
A Pharmacy Partner You Can Depend On

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SSN: _____

PATIENT PHONE NUMBER: (____) ____ -_____ ALT PHONE NUMBER: (____) ____ -_____

Patient Address: _____City/ST_____Zip_____

PLAN OF CARE

☐ (250.00) Type II unspecified, not stated uncontrolled ☐ (250.02) Type II unspecified type, uncontrolled

☐ (250.01) Type 1 Juvenile, not stated uncontrolled ☐ (250.03) Type 1 Juvenile, uncontrolled

☐ Other Diagnosis _____

Length of Need ..... ☐ 99 (lifetime) ☐ 12 (one year) ☐ Other _____

Number of Refills ..... ☐ 99 (lifetime) ☐ 12 (one year) ☐ Other _____

Is the patient newly diagnosed? ☐ YES ☐ NO **Is the patient treated with insulin?** ☐ YES ☐ NO

Has Medicare paid for a monitor within the last 5 years? ☐ YES ☐ NO

As this patient's healthcare provider, I prescribe the following glucose testing items:

☐ Glucose Monitor

☐ Test Strips, Control Solution, Lancets, Lancet Device, and Battery for monitor

Directions: Test blood glucose _____ times per day
QTY:_____

☐ Other/Notes:_____

***Medicare allows coverage for 100 strips and 100 lancets every 90 days for patients with NIDDM**

***Medicare allows coverage for 300 strips and 300 lancets every 90 days for patients with IDDM**

I certify that I am the treating physician identified on this form. I have received and completed the sections of this Prescription/Detailed Written Order (DWO). Any statement on my letterhead, attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I certify that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____ _____ _____
Physician Signature ***(No Stamps)*** **NPI #** **Order Date** ***(Required)***

Physician Name: _____ Office Name: _____
Office Address: _____ Phone: _____
City, State, ZIP:_____ Fax: _____