

Barcode:

### DETAILED WRITTEN ORDER

- K0554 Receiver (Monitor), dedicated, for use with therapeutic Continuous Glucose Monitor system - 1 unit Dexcom Receiver
- K0553 Supply allowance for therapeutic Continuous Glucose Monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service

EST. LENGTH OF NEED (# OF MONTHS):

ORDER DATE: MM/DD/YYYY

PATIENT INFORMATION

Patient Last Name:  Patient First Name:

Date of Birth:  /  /  Patient Address:

City:  State:  Zip:

Phone Number:  -  -  Dexcom Account #:

Primary Insurance Name:  Member ID:

Secondary Insurance Name:  Member ID:

PHYSICIAN INFORMATION

Physician Last Name:  Physician First Name:

Phone Number:  -  -  Hospital/Clinic:

Fax Number:  -  -  Hospital/Clinic Address:

City:  State:  Zip:

NPI #:

STATEMENT OF MEDICAL NECESSITY

Currently on CGM Therapy?  Yes  No #SMBG  per day # Multiple Daily Injections per day

Date of Last Visit (Must be within 6 months of this order):  /  /  On insulin pump?  Yes  No

Diagnosis Code: ICD-10 Code:  E10.65  E10.9  E11.9  Other

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring System, Dexcom Sensors, Dexcom Replacement Transmitter or Dexcom Replacement Receiver, and all associated diabetes supplies to be provided by Dexcom or an authorized distributor.

I certify that I am the physician identified on the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge.

Signature:  Date:  /  /