Hayat
Home Medical Equipment

Fax Your Illinois Order to 708-422-5966

Thank You!

PRESCRIPTION ORDER FORM



Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

_____

Order Date: _____ / _____ / _____

Medicare/Commercial **E2103 A9278 (Dexcom G7 Receiver)** ☐	**Medicare/Commercial** **A4239 A9276 (DexcomG7 Sensors)** ☐
1 Reader	1 Unit/30 Days or 3 Units/90 Days† (1 Unit = 1 month of sensor and supplies) - Sensor site changes per manufacturer guidelines Length of Need: Lifetime - unless specified otherwise: _____

1. Does the patient have diabetes mellitus? ❑ YES ❑ NO
2. Has the patient and/or caregiver had sufficient training using the CGM prescribed and is prescribed in accordance with its FDA indications for use? ❑ YES ❑ NO
3. Date of Last Office visit within 6 months to evaluate their diabetes control ____/____/____

Please CHECK which criteria patient meets:
❑ E10.9 ❑ E11.65 ❑ E10.65 ❑ E11.8 ❑ E11.9 ❑ Other: _____

Please CHECK the number **1 OR 2 BELOW** of which criteria patient meets:
❑ 1. The beneficiary is insulin-treated **OR**
❑ 2. The patient has a history of problematic hypoglycemia with documentation of at least one of the following:
- Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
- A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____

PLEASE FAX OFFICE NOTES ALONG WITH THIS PRESCRIPTION

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Home Medical Equipment

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PRESCRIPTION ORDER FORM



Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

_____

Order Date: _____ / _____ / _____

Medicare/Commercial **E2103 A9278 (FreeStyle Libre 3 Receiver)** ☐	**Medicare/Commercial** **A4239 A9276 (FreeStyle Libre 3 Sensors)** ☐
1 Reader	1 Unit/30 Days or 3 Units/90 Days† (1 Unit = 1 month of sensor and supplies) - Sensor site changes per manufacturer guidelines Length of Need: Lifetime-unless specified otherwise: _____

1. Does the patient have diabetes mellitus? ❑ YES ❑ NO
2. Has the patient and/or caregiver had sufficient training using the CGM prescribed and is prescribed in accordance with its FDA indications for use? ❑ YES ❑ NO
3. Date of Last Office visit within 6 months to evaluate their diabetes control ____/____/____

Please CHECK which criteria patient meets:
❑ E10.9 ❑ E11.65 ❑ E10.65 ❑ E11.8 ❑ E11.9 ❑ Other: _____

Please CHECK the number **1 OR 2 BELOW** of which criteria patient meets:
❑ 1. The beneficiary is insulin-treated **OR**
❑ 2. The patient has a history of problematic hypoglycemia with documentation of at least one of the following:
- Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
- A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____

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