DIABETES SELF-MANAGEMENT EDUCATION/TRAINING SERVICES ORDER FORM

Patient Information
Name_____ DOB _____ ☐ Male ☐ Female
Address _____
Phone (H) _____ Phone (Cell) _____ Phone(Work) _____
Email address _____
Language: ☐ English ☐ Spanish ☐ Other _____

Diabetes Diagnosis, Code-Include all pertinent comorbidities/complications

☐ DM Type 2 (without complications)-E11.9
☐ DM Type 2 (uncontrolled)-E11.65
☐ DM Type 2 (with unspecified complications)-E11.8
☐ _____
☐ DM Type 1 (without complications)-E10.9
☐ DM Type 1 (with unspecified complications)-E10.8
☐ Gestational DM-024.419
☐ _____

Service Requested CHECK ONE:
☐ Initial DSMT up to 10 hours or _____ hrs
(1 hr individual + 9 hrs group) once in a lifetime, must be used within 12 consecutive months following start of DSMT
OR
☐ Follow up DSMT up to 2 hrs group or individual or ____hrs
(every calendar year after initial benefit)

CHECK OR WRITE IN:
☐ All content (monitoring, psychological adjustment, disease process, physical activity, goal setting, meds, problem solving, risk reduction)
OR specific content as listed here _____

Special needs requiring covered hours to be provided as individual vs group

Check all that apply:
☐ Vision ☐ Hearing
☐ Physical ☐ Cognitive
☐ Language ☐ FQHC-all hrs are individual
☐ Additional individual training needed (e.g. injectable teaching)
☐ No class available within 2 months of referral

List # individual hrs here_____ (cannot exceed 10 for initial, 2 for follow up)

Labs (meet Medicare definition for diagnosis) if available

Fasting glucose ≥126mg/dl on 2 occasions
Fasting glucose _____ mg/dl Date _____ Fasting glucose _____ mg/dl Date_____

2 hr glucose challenge ≥ 200mg/dl on 2 occasions
2 hr glucose challenge_____ mg/dl Date_____ 2 hr glucose challenge _____mg/dl Date_____

Random glucose ≥ 200mg/dl with symptoms of uncontrolled diabetes
Random glucose _____ mg/dl Date_____

A1C_____ Date_____

I certify that I am managing this patient's diabetes and that the diabetes self-management training requested is needed to provide the beneficiary with the skills and knowledge to self-manage the condition.

Provider Name (print/stamp)	Signature
NPI # _____	Date_____
Group Practice Name_____	Phone #_____

Please fax referrals to 719-383-5457; Attn: Diabetes Education Team