



## Diabetes Self-Management Training Services Order Form

Instructions: Please fax completed form to Remington Drug Co (540) 439-9822

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: VA Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Diabetes Self-Management Training (DSME) Requested** (Content includes Monitoring of diabetes, psychological adjustment, nutritional management, medications, understanding diabetes as a disease process, physical activity, goal setting, problem solving, prevention, detection and treatment of acute complications, unless specified differently. *To specify differently, please circle desired content*)

Initial DSMT (up to 10 hours) *OR specify:* \_\_\_\_\_ hrs

Follow-up DSMT (up to 2 hours) *OR specify:* \_\_\_\_\_ hrs

1 on 1 DSMT due to special needs: (Please check one of the following below)

Vision  Hearing  Cognitive Impairment  Physical  Language

Additional Training Required

Diabetes Prevention Program (27 classes over 12 months)

### Diagnosis / Optional A1c Value:

Type 1 (E10.9)  Type 2 controlled (E11.9)  Type 2 uncontrolled (E11.65)

Pre-Diabetes (R73.03) Most Recent A1c/Date: \_\_\_\_\_

### Complications/Co-morbidities: (Please check all that apply)

Hypertension  Dyslipidemia  Stroke  Neuropathy  PVD  Kidney Disease

Retinopathy  CHD  Non-healing wound  Pregnancy  Obesity

Mental/Affective disorder  Other \_\_\_\_\_

**I certify that I am the provider managing this patient's diabetes or pre-diabetes**

**Provider Signature:** \_\_\_\_\_ **NPI#** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Group or Practice Name:** \_\_\_\_\_ **Ph:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** VA **Zip Code:** \_\_\_\_\_

Definition of Diabetes (Medicare):

Medicare coverage of DSMT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- A fasting blood sugar greater than or equal to 126 mg/dl on 2 different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

Other payors may have other coverage requirements.