Stoll's Pharmacy, Inc.
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Blood Glucose Monitoring

Patient Name: _____ Date of Birth ____/____/_____

Patient Street Address: _____City, ST, Zip: _____

Dear Doctor,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff for a **Blood Glucose Monitor** for your patient listed above. **Please fill in all pertinent information below so that your patient receives their full medical insurance benefit.**

1. Equipment Ordered: _____ New Order _____ Renewal Order Order Start Date_____/_____/_____
   Refill _____ Times Number Of Tests/Day _____
   E0607 Blood Glucose Monitor _____
   A4253 Blood Glucose Test Strips _____ 50 Count Box(es)/_____Day Supply
   A4259 Sterile Lancets _____ 100 Count Box(es)/ _____Day Supply
   A4258 Lancet Injector Qty _____ A4256 Test Control Soln Qty _____
   Date Patient Last Seen For Diabetes by Prescriber: _____/_____/_____
   Most Recent Hgb A1c:_____ Test Date: _____

2. Is this Patient being treated with insulin injections? [ ] Yes [ ] No

3. Pertinent Diagnosis (**ICD-10-CM Code**); Diabetes, Diabetic: _____

4. **MEDICARE UTILIZATION GUIDELINES*:** **Patients that are NOT treated with insulin=1 test per day**
   Patients that ARE treated with insulin=Up to 3 tests per day

If the above order exceeds these guidelines please indicate the reason(s) that your patient should exceed regulations (as indicated in your patient's chart):

5. Is the device designed for home use? [ ] Yes [ ] No

6. Is this patient capable of being trained to use the blood glucose monitor in an appropriate manner? [ ] Yes [ ] No

Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199

Prescriber Name: _____ **Prescriber NPI #:** _____

Street Address: _____**City, ST, Zip**_____

Signature: _____ **Date Signed:** _____/_____/_____

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES

Supervising Physician (if applicable) _____

Signing Prescriber's NPI # (if different from above) _____