HCS
Home Care Specialists
Treating people like family, since 1979.

Please Fax Completed Form To: 866-372-0380

For Any Questions, Please Contact Us At:

800-698-8113 Ext 556 or CGM@HCSHME.COM

Patient Name:_____DOB:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Email:_____ Provider Name:_____

Diagnosis: ☐ E10.9 Type 1 Diabetes Mellitus Without Complications ☐ E10.65 Type 1 Diabetes Mellitus With Hyperglycemia

☐ E11.9 Type 2 Diabetes Mellitus Without Complications ☐ E11.65 Type 2 Diabetes Mellitus With Hyperglycemia

☐ Other:_____

Continuous Glucose Monitoring: ☐ Initial New CGM ☐ Supplies For CGM

☐ FreeStyle Libre2 Receiver/Sensors ☐ FreeStyle Libre3 Receiver/Sensors

☐ FreeStyle Libre2 Plus Receiver/Sensors ☐ FreeStyle Libre3 Plus Receiver/Sensors (Plus sensors to be used with AID/insulin pumps)

☐ Dexcom G6 Receiver/Sensors/Transmitters ☐ Dexcom G7 Receiver/Sensors/Transmitters

☐ Other Receiver/Sensors/Transmitters/Supplies:_____

Insulin Pump: ☐ Initial New ☐ Replacement ☐ Supplies for Insulin Pump

☐Beta Bionics iLet ☐Tandem Basal IQ ☐Tandem Control IQ ☐Tandem Mobi ☐Other:_____

Cartridges:

☐ Syringe for external insulin pump, syringe type cartridge, sterile, 3cc

Make and Model needed: _____(if nothing listed, patient preference)

Change Frequency: Every __ days (3 = 1 box/month; 2 = 2 boxes/month; 1 = 3 boxes/month)

Infusion Sets:

☐ Infusion set for external insulin pump, non needle cannula type

☐ Infusion set for external insulin pump, needle type (example: Tandem Trusteel)

Make and model needed: _____(if nothing listed, patient preference)
Change Frequency: Every __ days (3 = 1 box/month; 2 = 2 boxes/month; 1 = 3 boxes/month)

Physician Name:_____Signature:_____

Physician NPI #:_____Date:_____Length of Need:_____(99 Lifetime)

Physician Attestation: I hereby authorize the use of this document as a legal prescription for the item indicated above. I certify that the above prescription is medically necessary and reasonable for the treatment of this patient.