Continuum
a CHC Solutions Company

PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

DIABETIC ORDER FORM

Please attach face sheet w/ patient demographics & insurance info*

PATIENT INFORMATION

Patient Name: _____ DOB: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Patient cannot accept deliveries on the following days?
☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat

Is the patient currently using insulin?: ☐ Yes ☐ No

DIAGNOSIS

Primary Diagnosis
ICD-10 Code: _____
*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis
ICD-10 Code: _____

PRODUCTS

Products	Testing Frequency	Total Quantity Dispensed (per 30 days)
☐ Prodigy Auto Code Glucometer	N/A	
☐ Prodigy Auto Code Testing Strips	_____x per day	
☐ Prodigy East Touch Lancets (30g)	_____x per day	
☐ Prodigy Lancet Device	_____x per day	
☐ Other	_____x per day	

Order Date: _____/_____/_____ **Length of Need:** _____ **months**

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____ /_____ /_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____ /_____ /_____