Diabetic
Equipment and Supplies

Certificate of Medical Necessity
Diabetic Equipment and Supplies, LLC
3100 SE Grimes Blvd., Suite 600, Grimes, IA 50111
Phone: (515) 478-3600 - FAX: (515) 478-3601

Please include the following: most recent clinic notes, blood sugar logs [Medicaid] and insurance card [if available]
Changes to form must be initialed and dated by prescriber.

Patient Name:	DOB:
Address:	Phone:
Primary Insurance:	ID #:
Secondary Insurance:	ID #:

Diagnoses (check all that apply):

☐ E10.65 – Type 1 DM with Hyperglycemia
☐ E11.65 – Type 2 DM with Hyperglycemia
☐ Other (please specify):_____
☐ E10.9 – Type 1 DM without complications
☐ E11.9 – Type 2 DM without complications

Continuous Glucose Monitors (CGMs)

DEXCOM

☐ Dexcom G6 CGM & Supplies: Receiver: use as directed, Transmitter: 1 per 3 months, Sensors: 1 per 10 days
☐ Dexcom G7 CGM & Supplies: Receiver: use as directed, Sensors: 1 per 10 days

FREESTYLE LIBRE

☐ Freestyle Libre 2 CGM & Supplies: Reader: use as directed, Sensors: 1 per 14 days.
☐ Freestyle Libre 3 CGM & Supplies: Sensors: 1 per 14 days.

OTHER CGM & SUPPLIES

☐ Manufacturer: _____ | Reader/Receiver: use as directed, Sensors: 1 per _____ days, Transmitter: 1 per _____ months.

Insulin Pump & Supplies

☐ Insulin Pump or PDM: use to deliver insulin, use as directed | Circle One: New or Upgrade | Manufacturer: _____
☐ Insulin Pump Supplies: Infusion Set, Cartridge/Reservoirs | Change how often: ☐ 3 Days ☐ 2 Days ☐ 1 Day
☐ OmniPod EROS: Pods | Change how often: ☐ 3 Days ☐ 2 Days ☐ 1 Day

Ancillary Supplies

☐ Adhesive/Tape/Wipes: Adhesive, Tape, Liquid Skin Tac, Skin Tac Wipes, Alcohol Wipes
☐ Ketone Strips: Ketone Strips
☐ Pen Needles/Syringes: Pen Needles, Syringes
☐ Blood Glucose Meter and Supplies: Meter, Test Strips, Lancing Device, Lancets: use as directed
☐ Other: _____

This document serves as a Prescription and Statement of Medical Necessity on the above referenced patient for the associated diabetes supplies listed. I certify, to the best of my knowledge, that the medical necessity information on this document is true, accurate and complete. The patient/caregiver is able to use the items as prescribed; has had training for these items and is informed they will be contacted by Diabetic Equipment and Supplies.

Prescription is valid for 1 year	Ship to: ☐Patient ☐Doctors Office	
Provider Name:	Provider Signature: (No signature stamps accepted)	
NPI #:	Phone #:	Order Date: