Byram Healthcare

Diabetes Referral Form

Referral name_____
Phone:_____
Clinic Fax: _____

Step 1 - Patient Information – attach face sheet that includes address and insurance information

▶ Patient name:_____ ▶ Phone: (_____)_____

Comments:_____

Signature Authorization - My signature on the line below authorizes any of the following. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the social Security Act) and/or any other Medical Insurance is correct. I authorize the release to Byram Healthcare any medical information including the diagnosis that may be necessary for insurance payment. I authorize the benefits payable to Byram Healthcare on assigned claims. I authorize Byram Healthcare to submit claims to Medicare and/or any other Medical Insurance carrier. I agree to assume responsibility for any balances for supplies furnished to me by Byram Healthcare not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance and non-covered items. I authorize that photo copies shall be valid as originals.

▶ **Patient Signature**_____ **Date**_____

Step 2 – HCP completes the following:

▶ **Supplies needed:**

☐ Test strips _____ (brand/name)
☐ Lancets
☐ Control Solution
☐ Batteries
☐ Other:_____
☐ Insulin syringes _____injections/day
□ 3/10 cc □ ½ cc □ 1 cc

▶ **ICD-9 Diagnosis Code:**

Insulin treated:
☐ 250.00 (Type 2)
☐ 250.01 (Type 1)
☐ 250._____
☐ 648.8 (Gestational)
☐ 648.03 (Pregnancy with pre-existing diabetes)

Non-insulin-treated:
☐ 250.00 (Type 2)
☐ 250.02 (Type 2)

☐ V23.9 high risk pregnancy

▶ **Testing frequency:**

☐ 1/day *(2 box of 50 test strips, 1 box lancets/3 mos)*
☐ 2/day *(4 box of 50 test strips, 2 box lancets/3mo)*
☐ 3/day *(6 box of 50 test strips, 3 box lancets/3 mo)*
☐ 4/day *(8 box of 50 test strips, 4 box lancets/3 mos)*
☐ _____/day

▶ **Length of need:** ☐ Lifetime or _____months

▶ **If gestational or pregnant, provide due date:** _____

▶ **Medical Necessity**: Provide an explanation for testing more frequently than 1x/day for non-insulin treated or 3x/day for insulin treated. I have prescribed this patient to test their blood sugar level more frequently than the above Medicare utilization guidelines because:

☐ Pediatric patient <18 yrs.
☐ Abnormal A1C
☐ Medication adjustment
☐ Urine ketones
☐ Irregular blood glucose
☐ Pregnancy
☐ Gestational diabetes
☐ _____

▶ **For WVCH patients:** In addition to this referral form, please include a copy of the patient's chart notes which addresses the need for increased testing frequency. (Not required for pediatric, gestational diabetes or pregnant patients)

Step 3 – Physician Signature

▶ **Physician Signature:**_____ ▶ **Date:** _____

▶ Physician Name:_____

My signature above indicates that the patient has diabetes and is/was being treated by me, authorizes this form as my order, verifies that I have seen the patient within the past 6 months and that the patient and/or caregiver has been trained on the use of blood glucose monitoring supplies.

Step 4 – Fax to Byram Healthcare @ 866.944.2544

Byram Healthcare – Portland **Fax: 866.944.2544** **Phone: 800.678.0707 x 35499**