DELTADRUGS

Diabetic Supplies

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ Medicare ID #: _____

ID#: _____ Phone #: _____ Medi-Cal ID #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ E10.0 Diabetes Mellitus Type I ❑ E11.0 Diabetes Mellitus Type II ❑ O24.____ Diabetes Mellitus in pregnancy

Some insurances require an explanation for frequent (more than 1xday) insulin and non-insulin testing. I confirm that this patient has been evaluated for their diabetes control within the last 6 months: _____ Initials

Reason for high testing frequency (Check all that apply):

❑ Fluctuating blood sugar ❑ Hypoglycemia ❑ Hyperglycemia ❑ Elevated HA1C levels

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

ITEM	QTY	PER MONTH	DURATION	DIRECTIONS
❑ TRUERESULT® GLUCOSE MONITOR				❑ QD ❑ BID ❑ TID ❑ QID ❑ UD
❑ TRUERESULT® GLUCOSE TEST STRIPS	❑ 50 ❑ 100 ❑ 200		❑ 12 months ❑ _____	
❑ LANCETS	❑ Box of 100			
❑ ALCOHOL PADS	❑ Box of 100			

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

By signing below, I confirm that the information contained on this Physician Order form accurately reflects the patient's diabetic condition and the treatement regimen that I have prescribed. The medical record for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. This device is designed for home use. For Medicare insurance requirements, I will maintain a signed copy of this document in the patient's file for post-payment purposes.

Physician's Signature: _____ Date: _____ ❑ Dispense As Written

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.