OrthoMedical
Serving your home medical equipment needs

Medicare **Standard Written Order**
for Continuous Glucose Monitering and Supplies

FreeStyle Libre 2

Instructions

1. Complete all fields on this Standard Written Order
2. Confirm coverage criteria and medical necesstity documentation requiremrnts are met
3. Send this order and the patient's most recent medical records demonstrating coverage criteria are met to OrthoMedical for the Freestyle Libre 2 system. FAX (833) 254-2640

Patient Information

Patient Name:_____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

Diagnosis (ICD-10 code that supports medical necessity

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other _____

Select, at least one, of the following documented reasons for prescribing CGM to improve beneficiary's glycemic control:

☐ Insulin-treated ☐ History of problematic hypoglycemia

Order Detail

Freestyle Libre 2 Reader	Freestyle Libre 2 Sensors
Use per manufacturer guidelines, in accordance with FDA indications for use _____ Duration of need: 99 months - unless specified otherwise: _____	Change Sensor every **14 days** **Dispense up to 90 day supply** Duration of need: 99 months - unless specified otherwise: _____

DISPENSE AS WRITTEN

I certify that I am the physician in the "Physician Information" section below and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ Date: _____

Physician Information

Physician Name:_____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Notes: _____

OrthoMedical provides this information as a courtesy, it is subject to change and interpretation. The customer is ultimately responsible for determining the appropriate codes , coverage, and payment policies for individual patients. OrthoMedical does not guarantee insurance coverage and payments for product or reimburse customers for claim that are denied by insurance companies.

Please fax prescription and all records to: OrthoMedical (833) 254-2640

1053 W Bridge St Blackfoot, ID 83221

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