



Diabetes Self-Management Education

PROVIDER ORDER

PATIENT INFORMATION

Patient's Last Name	First Name	Middle	
Date of Birth _____/_____/_____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
A1C _____	Weight _____	Blood Pressure _____	
Address	City	State	Zip Code
Home Phone	Other Phone	Email Address	

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T)

Check type of training services and number of hours requested.

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Initial group DSME/T: | <input type="checkbox"/> 8 - 10 hours |
| <input type="checkbox"/> Follow-up DSME/T: | <input type="checkbox"/> 2 hours |

Medicare Coverage: 10 hours initial DSME/T in 12-month period from the date of first class.

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply.

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Language Limitations | |
| <input type="checkbox"/> Additional Training | <input type="checkbox"/> Additional Hours Requested | |

DSME/T Content

Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Monitoring Diabetes | <input type="checkbox"/> Diabetes as Disease Process |
| <input type="checkbox"/> Psychological Adjustment | <input type="checkbox"/> Physical Activity |
| <input type="checkbox"/> Nutritional Management | <input type="checkbox"/> Goal Setting, Problem Solving |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Prevent, Detect and Treat Acute Complications |
| <input type="checkbox"/> Prevent, Detect and Treat Chronic Complications | |
| <input type="checkbox"/> Preconception/Pregnancy Management or GDM | |

DIAGNOSIS

Diagnosis Code _____

- | | |
|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Type 1 | <input type="checkbox"/> Type 2 |
| <input type="checkbox"/> Gestational | |

DEFINITION OF DIABETES (MEDICARE)

Medicare coverage of DSME/T requires the physician to provide documentation of a diagnosis of diabetes based on one of the following.

- A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions
- A 2-hour post-glucose challenge greater than or equal to 200 mg/ml on 2 different occasions; or
- A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register.

Other payors may have other coverage requirements.

APPOINTMENTS AVAILABLE IN-PERSON AND VIDEO VISITS

Additional Comments: _____

Signature and NPI # _____ Date/Time _____/_____/_____

Group/practice name, address and phone number: _____

For patient eligibility and outcomes monitoring, scan into patient chart and fax form to **606-789-6486**.

For questions or more information, feel free to contact

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