Physician Order- Diabetes Supplies

OTC Department
Please fax form at fax number
813-506-6275

Important Freedom Health information

Confidential Patient Information. For INTERNAL Use Only

PCP ID# :
PCP Name :
PCP Phone# :
PCP Fax# :
PCP Address :

Member ID:
Name:
DOB:
Phone:
Deliver Order#:
Order Date:

Dear Provider,

Your patient is requesting diabetic testing supplies from the OTC department. In order for us to fulfill in a timely manner, please fill out the below form and fax it back to us **immediately**. Thank you for your cooperation.

Physician to complete and Fax to: 813-506-6275

1. Does the patient currently have diabetes? (check one) ☐ Yes ☐ No

2. does the patient need to check his/her blood sugar daily? (check one) ☐ Yes ☐ No
If yes, then please select from below

☐ 1-time ☐ 2-times ☐ 3-times ☐ 4-times ☐ 5-times ☐ 6-times ☐ 7-times ☐ 8-times ☐ 9-times

3.How long will the patient need to test at the above frequency? (check one)
☐ 1-month ☐ 3-months ☐ 6-months ☐ 1-year

By my signature below, I confirm that the patient has diabetes and is being treated by me. Furthermore, the patient has been seen and evaluated for his/her diabetes within six (6) months of this order. All information contained in this diabetes order form accurately reflects the patient's diabetes diagnosis and the treatment regimen that I prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow instructions for controlling diabetes and has been instructed on the proper use of the ordered items. In accordance with medical requirements. I will maintain the signed original of this order in the patient's medical record file and acknowledge that the Health Plan has the right to request progress note for this patient.

Physician's signature: _____ Date: ____/____/_____

NPI#: ☐☐☐☐☐☐☐☐☐☐

Physician's Office Stamp with address here →

OTC Diabetic Supply FAX Form - Rev 11/18