

Date: ____/____/____ Referred by: _____

Patient Name: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____ Birth Date: ____/____/____

Day Phone: (____) _____ Home Phone: (____) _____ SS # ____ - ____ - ____

INSURANCE

Health Plan of Michigan

Member ID: _____

Other: _____

Contract/Policy #: _____

Group #: _____

Subscriber: _____

HEDIS DATA

Test	Most Recent Date of Test	Score/Result
LDL	_____	_____
Dilated Eye Exam	_____	_____
HbA1c	_____	_____
Microalbumin	_____	_____
Blood Pressure	_____	_____

Is patient treated with insulin? Yes No

SUPPLIES NEEDED

Glucose Meter Prodigy AutoCode

(please cross out those items not authorized for this patient)

Test Strips Control Solution

Lancets Lancing Device

(please check if needed)

Glucose Meter—Severe Visual Impairment

Numerical Visual Acuity = _____

DURATION OF NEED

12 months Other: _____

If no duration is specified, prescription defaults to 12 months.

RECOMMENDED TESTING

1 time a day 2 times a day 3 times a day

4 times a day 5 times a day 6 times a day

Other: _____

DIAGNOSIS

Pre-Existing New
(please check one)

250.01 Type 1

250.00 Type 2, controlled

250.02 Type 2, uncontrolled

648.80 gestational diabetes EDC: ____/____/____

Other: _____

Ordering Physician Name: _____ Date: ____/____/____

Physician Signature: _____ UPIN No.: _____

Address: _____ License No.: _____

Phone: (____) _____

Fax: (____) _____