



**Tri-State**  
Memorial Hospital &  
Medical Campus

# Outpatient Diabetes Self-Management Education Provider's Order Form

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## Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Referring Provider \_\_\_\_\_ Referral Date \_\_\_/\_\_\_/\_\_\_\_\_

## Insurance Information

Primary Insurance \_\_\_\_\_  
 Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

To meet CMS eligibility criteria one of the following must be met (please check all that apply): ICD 9 codes

- Fasting blood sugar greater than or equal to 126mg/dL on two different occasions 250. \_\_\_\_\_
- 2 hour post glucose challenge greater than or equal to 200mg/dL \_\_\_\_\_
- Random glucose test over 200 mg/dL for a person with symptoms of diabetes \_\_\_\_\_
- Type 1     Type 2     Gestational

**Initial Training:** Patient to receive a 1:1 initial assessment and education in the AADE - 7 Diabetes Self-Care goals which include:

- |                   |                      |                    |                   |
|-------------------|----------------------|--------------------|-------------------|
| 1. Healthy eating | 3. Taking medication | 5. Problem solving | 7. Reducing risks |
| 2. Being active   | 4. Monitoring        | 6. Healthy coping  |                   |

Medicare allows 10 hours of initial training, 9 of the 10 hours must be provided in a group setting unless special conditions exist. Please document any special needs of the patient:  Vision     Hearing     Language     Physical     Cognitive impairment

Other \_\_\_\_\_ *Other insurances vary in coverage*

**Follow up training** (either group or individual is allowed) 2 hours per year is the usual coverage. Please specify any special needs:

Insulin pump start     Insulin and other injectable starts     Other \_\_\_\_\_

## Professional Continuous Glucose Monitoring

Medicare Criteria for coverage of CGM T1 or T2 Diabetes, been instructed by a health care professional in the management of diabetes, documented frequency of glucose testing (4x/day) during the previous month, been on a program of multiple daily injections (2 per day min) with self adjustment AND met one of the following:

- A1C (<4 or >9), unexplained large fluctuations in daily glucose values before meals, unexplained frequent hypoglycemic attacks
- Episodes of Ketoacidosis or hospitalized out of control, Type 1 or Type 2 Diabetic woman who is newly pregnant or a woman who has developed a gestational diabetes that requires insulin therapy

## Personal Continuous Glucose Monitoring start

**Records needed from patient record:** Check if records are in Greenway EMR TSMH & MC, if not please send the following:

- |   |                                |  |
|---|--------------------------------|--|
| <input type="checkbox"/> H&P                        | <input type="checkbox"/> Lipid | <input type="checkbox"/> A1C                         |
| <input type="checkbox"/> Current list of medication | <input type="checkbox"/> CMP   | <input type="checkbox"/> Other pertinent lab results |

Other needs identified by PCP \_\_\_\_\_

Referring Provider's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_