One Source MEDICAL GROUP

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1-877-490-9111 FAX
1-866-834-7473 Phone

Your "One Source" for Diabetes Supplies
www.onesourcemedicalgroup.com

Patient Name	**DOB**
Address	**Phone#**
City, State, Zip	
Primary Insurance	**Ins ID #**
Secondary Insurance	**Ins. ID#**

DIABETES TESTING SUPPLY ORDER

☐Glucose Meter BRAND_____ ☐Lancet Device 1 unit (A4258)

☐Test Strips ☐Lancets ☐Alcohol Swabs ☐Ketone Strips for Urine #50

☐Insulin syringes Size ☐3/10cc ☐ ½ cc ☐1 cc Needle ga____ # of injections per day _____

☐Pen needles Size ☐ 4 mm ☐ 5 mm ☐ 8 mm Needle ga____ # of injections per day _____

How many times PER DAY should patient check their blood sugar?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **OTHER:**_____

Patient Diagnosis - ☐ Non Insulin ☐Insulin Using Z79.4

☐ E11.9 Type 2 without complication ☐ E11.8 Type 2 with unspecified complication

☐ E10.9 Type 1 without complications ☐ E10.65 Type 1 with hyperglycemia

☐ O24.429 Gestational diabetes ☐Other: _____

INSULIN PUMP SUPPLIES - PUMP MODEL:_____

☐ Infusion Sets - Brand/Style or Stock #:_____ Cannula size_____ Tubing Length_____

☐ Reservoirs/Cartridges _____

Infusion sets & cartridges to be changed every ☐2 days (2 boxes per mo) ☐ 3 days (1 box per mo)

☐ OmniPods A9274 ***change every ☐ 2 days (2 boxes per mo) ☐ 3 days (1 box per mo)***

☐Dexcom Sensors 1 box ☐ Dexcom Transmitter ☐ Dexcom Receiver

☐Transparent Dressing #100 ☐ Skin/ IV Prep Wipes 50's

☐ Other_____

☐ Other_____

Physician Information: My signature below acknowledges the medical necessity of the items specified on this order. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use.

Printed Name:	**Phone#** (352) 549-2273
Address	**Fax#**
City, State, Zip	**NPI#**

Physician Signature: _____ **Date:** _____

Number of refills ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Length of Need: 99 = lifetime unless otherwise noted here ___**99**____

START DATE OF ORDER:_____