Resupply Order Form

Insulin Pump & Supplies

Complete and Return
Fax to (207) 795-7622

PATIENT INFORMATION (PLEASE INCLUDE LAST 2 OFFICE VISIT NOTES)

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone Number: _____

Patient Email Address: _____

ORDER INFORMATION

Date of Last Office Visit: _____

Length of Need: _____ Number of Refills: _____

ICD-10 Dx Code: ☐ E10.9 ☐ E10.65 ☐ E11.9 ☐ E11.65 ☐ Other: _____

PRESCRIBED ITEMS

INSULIN PUMP(E0784): ☐ Tandem t:slim X2 ☐ Beta Bionics iLet Bionic Pancreas ☐ Medtronic 780g (includes E0607 and E2102)

☐ Tandem Mobi ☐ Medtronic 770g

INSULIN PUMP SUPPLIES: ☐ Infusion Sets (A4230/A4224) ☐ Steel Infusion Sets (A4231) ☐ Cartridges (A4232/A4225)

☐ Extended Infusion Set (1 per 7 days) ☐ Extended Reservoir (1 per 7 days)

☐ Extended Infusion Set (1 per 6 days) ☐ Extended Reservoir (1 per 6 days)

TDD (Total Daily Dose of Insulin)_____

Prescribed site change frequency for insulin pump supplies: ☐Every 3 days (#30 per 90 days) ☐Every 2 days (#50 per 90 days) ☐Every 1.5 days (#60 per 90 days) ☐Every day (#90 per 90 days) ☐Other: _____

If patient changes more frequently than every 3 days, indicate condition as documented in medical records:

☐Skin irritation ☐Scar tissue build up ☐Allergies ☐Catheter occlusion ☐Other: _____

Accessories:

☐IV Prep Wipes ☐Adhesive Remover ☐ Skin Prep ☐Transparent Dressings ☐Other: _____

QUALIFICATIONS

Medicare patients must meet the following guidelines to qualify:

- Patient has Diabetes
- Patient has a qualifying C-Peptide with same day fasting glucose or a positive Beta cell autoantibody test
- Patient is on multiple daily injections with frequent self-adjustments of insulin prior to initiation of insulin pump or the patient has been on an external insulin pump prior to enrollment in Medicare and has documented frequency of glucose self-testing
- Patient is seen within three (3) months prior to ordering the insulin pump supplies to evaluate their Diabetes control

PROVIDER INFORMATION

Healthcare Provider Name: _____ NPI: _____

Hospital/Clinic Name: _____

Address: _____ Phone: _____ Fax: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Email Address: _____