

Resupply Order Form

Continuous Glucose Monitoring

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

- CGM Brand:** Medtronic Simplera (site change per manufacturer's recommendation, 1 every 6 days) Dispense Qty _____
 Medtronic Instinct (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
 Medtronic Guardian (site change per manufacturer's recommendation, 1 every 7 days) Dispense Qty _____
 Dexcom G6 (site change per manufacturer's recommendation, 1 every 10 days) Dispense Qty _____
 Dexcom G7 (site change per manufacturer's recommendation, 1 every 10 days) Dispense Qty _____
 Dexcom G7 15-Day Wear (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
 Libre 2 Plus (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
 Libre 3 Plus (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____

CGM Components:

- CGM Receiver/Monitor — E2103 (Change 1 every 5 years)
E2102 (Change 1 every 5 years)
A9278 (Change 1 every 365 days)
 CGM Sensors — A4239 (Bill 1 every month or 3 every 3 months)
A4238 (Bill 1 every month or 3 every 3 months)
A9276 (1 unit per day)
 CGM Transmitter — A4239 (Bill 1 every 3 months)
A9277 (Fasten on top of sensors to check glucose daily. Change 1 every 90 days or 1 every 365 days for Medtronic)

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 is insulin treated or has a history of problematic hypoglycemia with documentation
- Patient is required to have and use receiver with CGM system
- Patient is seen within six (6) months prior to ordering the CGM, 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: _____



Phone: (207) 784-3700



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Refer through Parachute Health