DIABETIC ENROLLMENT FORM

PLEASE FILL OUT COMPLETELY AND FAX TO THE NUMBER BELOW. KEEP ORGINAL COPY FOR YOUR FILES.

3634 McCain, Suite 4 – Jackson, MI 49203

Phone: 517-783-4116 Fax: 517-783-4885 TOLL FREE (866) 458-4116

PATIENT INFORMATION:

Patients Last Name:______________________First:________________MI:____SS #___________________

D/O/B ___/___/___ Gender: M____F___ E-mail Address:____

Address: ______________________________________ City, State, Zip:_____________________________

Daytime Phone #:(_____)_______________________Alternate Phone #:(__ __)________________________

PHYSICIAN INFORMATION:

Physician's Name: _____________________________Office Contact: ______________________________

Phone #: (_____)___________________ Fax #: (_____)___________________ UPIN #: ________________

Address:_____________________________________City, State, Zip:_______________________________

INSURANCE INFORMATION:MEDICARE AND PRIVATE INSURANCE ACCEPTED-NO HMO's

Primary Insurance: _______________________________________Phone #:_________________________

Group #:_____________________Policy #:__________________Policy Holder Name: _________________

Secondary Insurance:_____________________________________Phone #:_________________________

Group #:_____________________Policy #:__________________Policy Holder Name:__________________

ASSIGNMENT OF BENEFITS / HIPPA DISCLOSURE

By signing this form, I authorize the release of any medical or other information necessary to bill my insurance provider on my behalf. I also authorize payment with medical / government benefits to Spectrum Diabetic Services for equipment or supplies provided to me. I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

I also acknowledge the receipt of the following:

*Patient Rights & Responsibilities
*Consent to Privacy Practices.
*Notification of Information Practices
*Notice of Privacy Practices
*21 Medicare Supplier Standards
*Spectrum Diabetic Services, LLC Pertinent Information Sheet & Return Policy

____ ______________

Patient Signature Today's Date

PHYSICIAN'S ORDER

Date of Order: _____________ Patient Name: __________________________

Date of Birth: _____________ Phone# ________________________

IS PATIENT INSULIN TREATED?

1. ___ YES- Insulin Treated 2. ____ NO-Non- Insulin Treated
3. Diagnosis: ___ 250.01 ____ OTHER 4. Diagnosis: ____ 250.00 ____ 648.00

___ 250.02 ____ 250.03 ____ 250.02 ____ OTHER

5. Number of Tests Prescribed Per- Day __1 __2 __3 __4* __5* Other_______
   * As required by insurance, a specific narrative statement to support this frequency of testing is required: ____
   ____

   (e.g. frequent high / low blood sugar, history of ketoacidosis, intensive treatment)

   STRIPS / LANCETS used in a 30 day period based on daily usage:

1/ Day = 50	4 / Day = 150
2/ Day = 100	5 / Day = 150
3/ Day = 100	6 / Day = 200

6. With Respect to this Patient:
   _____ Evaluated within last 6 months
   Items prescribed include: home glucose monitor, test strips, lancets, lancing devices, batteries and control solutions.
   _____ Capable of following instructions for controlling diabetes and is able to use prescribed items.

7. __________________________ _______________ Duration of need:
   Physician's Signature Date 12 months or other _______

8. Physician's Name: ____
   Address: ____
   Phone: _______________________ Fax: _______________________
   E-Mail: ____