**DIABETES SELF-MANAGEMENT EDUCATION/TRAINING SERVICES ORDER FORM**

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| Patient InformationName\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ 🞏 Male 🞏 FemaleAddress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Language: 🞏 English 🞏 Spanish 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| ***Diabetes Diagnosis, Code-Include all pertinent comorbidities/complications***  |
| 🞏 DM Type 2 (without complications)-E11.9 🞏 DM Type 1 (without complications)-E10.9 🞏 DM Type 2 (uncontrolled)-E11.65 🞏 DM Type 1 (with unspecified complications)-E10.8 🞏 DM Type 2 (with unspecified complications)-E11.8 🞏 Gestational DM-024.419🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Service Requested CHECK ONE:**🞏 Initial DSMT up to 10 hours or \_\_\_\_\_\_\_ hrs (1 hr individual + 9 hrs group) once in a lifetime, must be used within 12 consecutive months following start of DSMT **OR**🞏 Follow up DSMT up to 2 hrs group or individual or \_\_\_\_hrs (every calendar year after initial benefit)**CHECK OR WRITE IN:**🞏 All content (monitoring, psychological adjustment, disease process, physical activity, goal setting, meds, problem solving, risk reduction) **OR** specific content as listed here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Special needs requiring covered hours to be provided as individual vs group***Check all that apply:*🞏 Vision 🞏 Hearing🞏 Physical 🞏 Cognitive🞏 Language 🞏 FQHC-all hrs are individual🞏 Additional individual training needed (e.g. injectable teaching)🞏 No class available within 2 months of referralList # individual hrs here\_\_\_\_\_\_ (cannot exceed 10 for initial, 2 for follow up) |
| **Labs (meet Medicare definition for diagnosis) if available** |  |
| Fasting glucose ≥126mg/dl on 2 occasionsFasting glucose \_\_\_\_\_\_ mg/dl Date \_\_\_\_\_ Fasting glucose \_\_\_\_\_\_ mg/dl Date\_\_\_\_\_2 hr glucose challenge ≥ 200mg/dl on 2 occasions2 hr glucose challenge\_\_\_\_\_\_ mg/dl Date\_\_\_\_\_ 2 hr glucose challenge \_\_\_\_\_\_mg/dl Date\_\_\_\_\_Random glucose ≥ 200mg/dl with symptoms of uncontrolled diabetesRandom glucose \_\_\_\_\_ mg/dl Date\_\_\_\_\_  |
| I certify that I am managing this patient’s diabetes and that the diabetes self-management training requested is needed to provide the beneficiary with the skills and knowledge to self-manage the condition. |
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| Provider Name (print/stamp) | Signature |
| NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Group Practice Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |