360 DEGREE Patient Care
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Medicare Requirements for Diabetic Strips

Requirements for the Written order from the doctor
1) Patient Name
2) Specific frequency of testing (**NO MORE PRN OR AS NEEDED ORDERS**)
3) Length of need for test strips
4) Doctor's name and signature
5) Start date of order if different than signed date

Maximum Glucose Testing Supplies Allowances

Patient Type	**Maximum Allowance (EVERY 3 MONTHS)**
Insulin Dependent	300 test strips (testing three times a day) 300 lancets (three times a day)
Non-insulin Dependent	100 test strips (once a day) 100 lancets (once a day)

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jayhawk patient supply
2620 SW 6th Ave.
Topeka, KS 66606
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Fax: 785-235-9703

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SPEED SCRIPT DIABETIC FORM
785-228-9700
785-228-1375 FAX

Patient Name:_____DOB:_____DATE:_____

>Patient Diagnosis: __ Type 1 Controlled (250.01) __Type 1 Uncontrolled (250.03)
__Type 2 Controlled (250.00) __Type 2 Uncontrolled (250.02_
__Other:_____

>Does the patient use insulin: __Yes __No

>Testing Frequency:_____Times/Day
__TrueTrack Meter
__TrueTrack test strips Qty:_____ Refills:_____
__Reliamed Lancets Qty:_____ Refills:_____

>MEDICARE UTILIZATION GUIDELINES:
TYPE 1 DIABETIC: ALLOWED #300 TEST STRIPS AND LANCETS PER 100 DAYS
TYPE 2 DIABETIC: ALLOWED #100 TEST STRIPS AND LANCETS PER 100 DAYS
Medicare requires an explanation for testing more frequently than 1x day non-insulin and 3x day insulin treated: therefore, I confirm that I have evaluated this patient within the last six(6) month to assess their diabetes control and have noted below the reason(s) for high testing frequency.
I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this patient's condition. By signing this form, I am confirming that the above information is accurate.

Physician Name:_____NPI_____

Physician Signature _____Date: _____

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