

DOCTOR ORDER

Your patient has ordered a Vacuum Erection System from us.

Instructions: Please fill in both Sections and fax back to Medico Express HealthCare at 1-800-859-4795

Patient Information	Physician Information
Name _____	Name _____
Address _____ _____	Contact: _____
Telephone: (____) _____ - _____	Address: _____
HICN: _____	Telephone: (____) _____ - _____
DOB ____/____/____	Fax: (____) _____ - _____
	UPIN #: _____

Items and quantities not to exceed this order and subject to patient's order, actual use and insurer guidelines

- 1 → ____/____/____ - Most recent date this patient's diabetes control was evaluated & charted.
- 2 → **START** date of Order ____/____/____
- 3 → **LENGTH** of Order : _____ or if other _____ (Specify length in months , weeks or days)
- 4 → **DIAGNOSIS:** 250.00 • 250.01 • Other: _____
- 5 → **TREATMENT** with insulin injections: Yes No
- 6 → **TESTING REGIMEN** and strip /lancet quantity to be provided
 - 1x/day (100 strips & lancets/ 3 months) 2x/day (200 strips & lancets/ 3 months) 3x/day (300 strips & lancets/ 3 months)
 - 4x/day (400 strips & lancets/ 3 months) 5x/day (450 strips & 500 lancets/ 3 months) 6x/day (550 strips & 600 lancets/ 3 months)
 - 7x/day (650 strips & 700 lancets/ 3 months) 8x/day (750 strips & 800 lancets/ 3 months) Other: _____ times per _____
- 7 → **MEDICARE UTILIZATION REQUIREMENT**

FOR TESTING MORE FREQUENT THAN 1X/DAY – NON-INSULIN PATIENTS OR 3X/DAY – INSULIN INJECTING PATIENTS;
MEDICARE REQUIRES THE TREATING PHYSICIAN HAS SEEN THE PATIENT, EVALUATED THEIR DIABETES CONTROL AND DOCUMENTED SUCH IN THE MEDICAL RECORDS WITHIN 6 MONTHS PRIOR TO ORDERING THIS TESTING REGIMEN AND EVERY 6 MONTHS THEREAFTER.

■ **Please Provide the Documented Reason for the Ordered Testing Regimen**

Hypertension/High Blood Pressure Fluctuating Blood Sugar Levels Adjusting Medication
 Other : _____
- 8 → **PRODUCT ORDER**

CROSS OUT (STRIKE THROUGH) EACH ITEM YOU DO NOT WISH TO AUTHORIZE/ORDER

 - 1 ea. Home Blood Glucose Testing Device (Meter) • Lancets per testing regimen and actual use
 - Test Strips/ Cartridges per testing regimen and actual use • Spring powered lancet device 1 every 6 months
 - Testing Device Replacement Batteries per mfg. requirements • Testing Device Control Solution per mfg. requirements
- 9 → **BY SIGNING BELOW**, I agree to maintain the original, signed copy of this document in my medical records. My medical records substantiate I was treating this patient under a comprehensive care plan for Diabetes Mellitus on the start date (above) and that this patient (or caregiver) is able to use the items herein ordered to manage the patient's glycemic control. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

SIGNATURE : _____
Ordering Physician's Signature and Date

DATE: _____

NPI: _____
NPI Required for validation



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Fax: 1-800-000-0000
Physician Help Line: 1-800-000-0000