



**WRIGHT &
FILIPPIS**

2638 Bond Street
Rochester Hills, MI. 48309
(800)343-4944 • (800)403-0592 Fax
www.FirstToServe.com

FAX COVER SHEET

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Date:

Dear Dr.:

Re: Diabetic Supply Patient:

To assist this patient with their insurance coverage, please complete the following form which supports the need for the supplies requested.

Please be sure to complete all of the sections, including:

1. Check **ALL SUPPLIES NEEDED** for the duration of prescription (i.e. batteries, control solution).
2. Check number of *tests per day*.
3. Check the appropriate *diagnostic code*.
4. Check whether the patient is **INSULIN-TREATED** or **NON INSULIN-TREATED**.
- 5A. If applicable, please indicate why this **NON INSULIN-TREATED** patient should test *more than one time per day*.
- 5B. If applicable, please indicate why this **INSULIN-TREATED** patient should test *more than three times per day*.
6. Check the appropriate *duration of need*.
7. Indicate whether the patient has been seen *within the last six months* prior to prescription date.
8. Insurance requires *signature of physician* on the form,

OR

the *printed name with NPI* number of Physicians Assistant or Nurse Practitioner signing on their behalf.

Finally, please include the *date of order* after physician's signature.

If you have any questions, please do not hesitate to contact us.

Thank you,

Central Supply Department
Wright & Filippis
(800) 343-4944

Please fax the completed form to (800) 403-0592

Note: The information contained in this transmission is privileged and confidential. It is intended for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or duplication of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. These documents should then be destroyed. Thank you.

Wright & Filippis
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Mi 48309
Ph: 800-343-4944
Fax: 800-403-0592



WRIGHT & FILIPPIS

(*) Primary
Secondary
Reorder#:

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Patient Information

Prescription *R_x*

(*) Beneficiary:

(*) Date of Service:
(*) Home Phone:
(*) Birthdate:

(*) Physician:

(*) Dr. Phone:
Dr. Fax:
(*) NPI:

(*) 1. HOME GLUCOSE TESTING SUPPLIES *(Please check all that apply)*

- Blood Glucose or Reagent Strip Home Glucose Monitor
- Lancets Replacement Batteries for Monitor
- Lancing Device Normal, Low and High Control Solution

(*) 2. TESTS PER DAY:

1=30 per month 2=60 per month 3=90 per month 4=120 per month Other: ___ = ___ per month

(*) 3. DIAGNOSIS CODE: 250.00 250.01 Other _____

(*) 4. IS THE PATIENT INSULIN TREATED? Yes No

(*) 5. PLEASE EXPLAIN WHY...

A. NON INSULIN-TREATED PATIENT IS TESTING *(MORE THAN ONE TIME PER DAY)*

- Fluctuating Blood Sugar Uncontrolled Intensive Treatment
- Hypertension Other: _____

B. INSULIN-TREATED PATIENT IS TESTING *(MORE THAN THREE TIMES PER DAY)*

- Fluctuating Blood Sugar Uncontrolled Intensive Treatment
- Hypertension Other: _____

(*) 6. DURATION OF NEED: 12 months 99 months Other: _____

(*) 7. HAS THE PATIENT BEEN SEEN WITHIN THE LAST SIX MONTHS? Yes No

Patient (Caregiver) is able and trained in the use of glucometer and is capable of using the test results for appropriate glycemic control.

(*) 8. PHYSICIAN SIGNATURE _____ DATE _____

Note: If quantities of supplies exceed utilization guidelines, there must be documentation in the physician's record reflecting the frequency of testing times.