ONE SOURCE MEDICAL SOLUTIONS, INC.

ONE COMPANY. MULTIPLE SOLUTIONS.™

COVERAGE CRITERIA FOR DIABETIC SUPPLIES

CLIENT NAME: _____ MEDICARE NO.: _____

DATE OF BIRTH: _____ HEIGHT: ___" WEIGHT: ___ LBS.

ADDRESS: _____

TELEPHONE: _____

LAST EXAMINATION DATE: _____

IS THE PATIENT BEING TREATED WITH INSULIN INJECTIONS? YES_____ NO_____

NARRATIVE STATEMENT OF MEDICAL NECESSITY DETAILING THE CONDITIONS THAT SUPPORT THE NEED FOR MORE THAN 100 TESTING STRIPS (A4253) AND MORE THAN 100 LANCETS (A4259) WITHIN 3 MONTHS.

♦**THIS IS NOT THE PRESCRIPTION, THIS DOES NOT TAKE PLACE AS MEDICAL RECORDS**♦

Months Needed _____ (99 = Lifetime)

TREATING PHYSICIAN: _____

ADDRESS: _____

PHONE NO.: _____ FAX NO.: _____

TREATING PRACTITIONER'S SIGNATURE: _____

DATE SIGNED: _____ NPI: _____

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