

Certificate of Medical Necessity

This form serves as a Prescription and Certificate of Medical Necessity for the Pelikan Sun® electronic lancing device and lancet disks.

PATIENT NAME (FIRST / LAST) / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
PATIENT DOB (MM/DD/YYYY)		
ADDRESS (NO P.O. BOX)		
CITY	STATE	ZIP
INSURANCE SUBSCRIBER ID#		

HOME PHONE - -	WORK PHONE
CELL PHONE	
EMAIL ADDRESS / /	
DATE DIAGNOSED	<input type="checkbox"/> Type 1 (250.01) <input type="checkbox"/> Type 2 (250.00) <input type="checkbox"/> Gestational (648.00)
AGE AT DIAGNOSIS	ICD-9 CODE

CLINICAL INDICATIONS FOR ELECTRONIC LANCING IN BLOOD GLUCOSE MONITORING

<input type="checkbox"/> Pediatric patient	<input type="checkbox"/> Patient has been hospitalized due to hypoglycemia unawareness
<input type="checkbox"/> High sensitivity to pain	<input type="checkbox"/> Diabetic ketoacidosis
<input type="checkbox"/> Testing anxiety that negatively impact BG testing compliance	<input type="checkbox"/> Additional indications to support need:
<input type="checkbox"/> Residual bruising and/or callouses, impacting patient's normal daily activities	
<input type="checkbox"/> Elevated or wide fluctuations in BG values ranging from ____ mg/dl to ____ mg/dl	
<input type="checkbox"/> High-frequency BG testing, ____ times / day	<input type="checkbox"/> HbA1C Value ____ % Date: ____
<input type="checkbox"/> Number of insulin injections per day ____	<input type="checkbox"/> HbA1C Value ____ % Date: ____

Physician Information

CLINIC / PRACTICE NAME		
OFFICE ADDRESS		
CITY	STATE	ZIP
UPIN#		

PRESCRIBING PHYSICIAN NAME (PRINT)
NPI: (National Provider Identifier – Required)
OFFICE CONTACT NAME - -
OFFICE PHONE

PHYSICIAN SIGNATURE

DATE