Prescription Center of Ossining
74 Croton Ave
Ossining, NY 10562
(914) 941-1660

Order for Diabetic Supplies

Date:____________________ Duration of need:_______________________(max. 3 mos., 1 refill allowed)

Patient Name___________________________ D.O.B._______________ Medicare #_________________

1. Is the patient using insulin to control their form of diabetes? _____yes _____no

2. Prognosis:____

3. IC9 code: _____250.00 _____250.01 _____250.002 _____250.03 _____other

4. Patient's testing frequency per day: _____1xday=100 _____2xday=200 _____3xday=300

5. Medicare requires explanation for testing more frequently than 1x day non-insulin treatment or 3x day insulin treatment.

   I am prescribing this patient to test his/her blood sugar levels more than the above guidelines

   because____

   ____.

6. I am prescribing the following for my patient:

_____Test strips _____lancets _____control soln. _____lancet device _____battery _____glucose monitor

7. My patient currently has a home glucose monitor _____yes _____no

By my signature below, I am stating that my patient has diabetesand is/was being treated by me. All the information contained on this Doctor's Order Form accurately reflects the patient's diabetic condition and the treatment regimen I have prescribed. I have seen this patient within the last six months to evaluate his/her diabetes control and this document confirms my order. My medical records substantiate the prescribed testing frequency. The patient or caregiver is able to use the ordered items. I maintain a copy of this signed original Doctor's Order Form in the patient's medical record file and will make it available for Medicare Insurer audit purposes.

Physician Signature____ Date:________________________

Physician Name:____

Address ____

Telephone Number ____________________________ UPIN Number: _____ _____ _____ _____ _____ _____

I have requested and received the supplies as prescribed by my physician at this pharmacy. I understand that the Pharmacy may use this requestform for billing, treatment or informational purposes.

Patient Signature____ Date:________________________