CGM Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to Continuous Glucose Monitoring (CGM) coverage criteria sheet for all required documentation.

CONTINUOUS GLUCOSE MONITOR:

Diagnosis and Code: _____

☐ E10.9 Type 1 Diabetes Mellitus without Complications
☐ E11.8 Type 2 Diabetes Mellitus with Unspecified Complications
☐ E11.65 Type 2 Diabetes Mellitus with Hyperglycemia
☐ E11.9 Type 2 Diabetes Mellitus without Complications
☐ Other: _____

Date of Last Visit: _____ Length of Need (of months) _____ 1-99 (99=lifetime)

☐ Continuous Glucose Monitor/Receiver
☐ Sensor – 1 Unit every 30 days (A4239) or 1/day (A9276) (1unit = 1 month)
☐ Transmitter – 1 every 3 months

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____