MUNSON HEALTHCARE

PATIENT ID LABEL HERE

# DIABETES SELF-MANAGEMENT EDUCATION/TRAINING AND MEDICAL NUTRITION THERAPY REFERRAL FORM

## Patient Information

Patient's Legal Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____/_____/_____ Home Phone: (____)_____ Other Phone: (____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance: _____ Prior Authorization #: _____

## Diabetes Diagnosis

| | ICD-10 |
|---|---|
| ☐ Type 1 Diabetes | E10.9 |
| ☐ Type 2 Diabetes | E11.9 |
| ☐ Gestational Diabetes | O24.419 |
| ☐ Pre-existing Type 1 Diabetes in pregnancy | O24.019 |
| ☐ Pre-existing Type 2 Diabetes in pregnancy | O24.119 |
| ☐ Pre-diabetes | R73.03 |

*Diabetes self-management education/training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.*

## Lab Eligibility:

*Medicare requires verification of diabetes diagnosis by one of the following for type 1 and type 2 diabetes:*

☐ FBG > 126 mg/dl on 2 tests:
FBG: _____ and FBG _____

☐ 2 hr OGTT > 200 mg/dl on 2 tests:
2 hr OGTT: _____ and 2 hr OGTT: _____

☐ Random BG > 200 mg/dl with symptoms of uncontrolled diabetes: Random BG: _____

## Other Labs: ☐ See Power Chart

☐ HgbA1C: _____% Date: _____

## Diabetes Self-Management Education/Training (DSME/T)

*Medicare coverage: 10 hours initial and 2 hours each year thereafter*

**The patient is to attend the following:**

☐ Initial Diabetes Self-Management Training (10 hours) ☐ ____ hours requested
*Includes all ten content areas, as appropriate, based on assessment*

☐ Annual Update (2 hours) ☐ _____ hours requested

**This patient cannot effectively participate in group instruction because of the following special needs:**

☐ Physical ☐ Language limitation ☐ Cognitive impairment
☐ Hearing/Vision ☐ Learning disability ☐ Other: _____

**Additional Self-Management Training Request**

☐ Pre-diabetes Group *(1 time class)*
☐ Diabetes Prevention Program as available *(12 month program)*
☐ GDM Class or ☐ Pre-existing Diabetes in Pregnancy Class
☐ Additional Insulin Training (1:1) *Complete Insulin Instruction Checklist, form #10934*
☐ Pump Assessment/Start-up ☐ Pump Upgrade
☐ Pump w/ Sensor Training ☐ Sensor Training
☐ Professional Continuous Glucose Monitor
☐ Injection Therapy Education *GLP / Other:* _____

## Medical Nutritional Therapy (MNT)

*Medicare requires signature of an MD or DO for MNT*

☐ Initial MNT
☐ 3 hours ☐ _____ hours

☐ Annual follow-up
☐ 2 hours ☐ _____ hours

☐ Additional reinforcement of nutrition in the same calendar year per RD
☐ _____ hours requested

**Specific Instructions:** _____

Provider's Signature: _____ Date: _____ Time: _____

Provider's Printed Name: _____ NPI #: _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

**MHC Cadillac Hospital Diabetes Education**
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