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: _____

Site to schedule patient at:

☐ Atlanta ☐ Grayling ☐ Hillman
☐ Onaway ☐ Prudenville
☐ Roscommon ☐ Rogers City

Provider's Signature:_____ Date/Time:_____

Provider's Printed Name:_____ NPI #:_____

Practice Name: _____

Address: _____

Phone Number:_____Fax Number:_____

MHC Grayling Hospital Diabetes Education
Ph: 989-344-5857 F: 231-935-7873