

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

- Type 1 Diabetes
- Type 2 Diabetes
- Gestational Diabetes
- Pre-existing Type 1 Diabetes in pregnancy
- Pre-existing Type 2 Diabetes in pregnancy
- Pre-diabetes

ICD-10

- E10.9
- E11.9
- O24.419
- O24.019
- O24.119
- R73.03

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: _____

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.

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: _____


MMC Diabetes Education
 Ph: 231-935-8200 F: 231-935-8215

MHC Charlevoix Hospital Diabetes Education
 Ph: 231-547-8801 F: 231-935-7878

MHC Manistee Hospital Diabetes Education
 Ph: 231-935-8200 F: 231-935-8215

POMH Diabetes Education
 Ph: 231-352-2260 F: 231-935-8215

OMH Diabetes Education
 Ph: 989-731-7872 F: 989-731-7837

KMHC Diabetes Education
 Ph: 231-258-3091 F: 231-258-3600