**Kansas Medical Assistance Program**
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

# PHYSICIAN ORDER FORM

## Medical Necessity for Diabetes Testing Supplies

**(This form suffices as a script. Requests will not be considered without a PA request form completed by the DME provider, including use of appropriate HCPCS codes and modifiers.)**

Beneficiary name: _____

Beneficiary Medicaid ID #: _____Date of birth: _____/_____/_____

**Diabetes ICD-10 Diagnosis Code**

□ **E11.9 Type 2 diabetes mellitus without complications**

□ **E13.9 Other specified diabetes mellitus without complications**

□ **E10.9 Type 1 diabetes mellitus without complications**

□ **E11.65 Type 2 diabetes mellitus with hyperglycemia**

□ **E10.65 Type 1 diabetes mellitus with hyperglycemia**

□ **024.4__* Gestational diabetes mellitus EDC: _____/_____/_____**

□ **099.81_* Abnormal glucose complicating pregnancy, childbirth and the puerperium**

**EDC: _____/_____/_____**

□ **Other**_____

***These codes require a sixth digit.**

**Physician Order for Blood Glucose Testing**

Testing frequency _____ times daily

Length of need _____

Diabetes being treated with insulin?

□ Yes ____ injections daily.

□ No, it is treated by _____

Reason for greater frequency of testing is:

□ fluctuating blood sugar □ uncontrolled blood sugar □ hypoglycemia

□ other (explain):

_____

The additional test results will be used to: _____

_____

This patient has been seen, and I have evaluated their control within the last 6 months: □ Yes □ No

Please print physician name: _____

Physician's Kansas Medicaid provider ID#: _____Physician's Kansas NPI #: _____

Physician/ARNP/PA signature: _____ Date: ____/____/_____

Completed form should be faxed to 1-800-913-2229.

**This form will be returned unprocessed if it is not completed in its entirety.**

If this request is not received within 15 working days, PA will be denied.

*Revised 10/2015*