Diabetes Self-Management Education/Training Services Order Form

Please complete all sections on front and back of form

Patient Information

Patient's Last Name _____ First Name _____ Middle _____

Date of Birth _____/_____/_____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-mail address _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

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

Check type of training services and number of hours requested

☐ Initial DSME/T: 10 hours (1 individual + 9 group) once in a lifetime benefit and must be used within 12 consecutive months following start of DSMT or _____No. hrs. requested

☐ Follow-up DSME/T: 2 hours (either group or individual) every calendar year after Initial benefit is used or _____No. hrs. requested

If not appropriate for group, select reason below

Patients with special needs requiring individual (1 on 1) DSME/T hours versus group

Check all special needs that apply:

☐ Visual impairment
☐ Cognitive Impairment
☐ Hearing Impairment
☐ Physical limitation
☐ Language Limitation
☐ Additional training needed (injectable)
☐ Change in medical condition/tx/dx
☐ Telehealth
☐ Additional hours requested _____hours

DSME/T Content

All content areas will be covered as needed per individualized education plan, unless otherwise specified

Monitoring Diabetes	Diabetes as disease process	Medications
Psychological adjustment	Physical Activity	Prevent, detect, treat complications
Nutritional management	Goal setting, problem solving	Preconception/pregnancy/GDM

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DIAGNOSIS

☐ Type 1 Diagnosis code _____

☐ Type 2 Diagnosis code _____

☐ Gestational Diagnosis code _____

Please send recent labs for patient eligibility & outcomes monitoring

Glucose_____mg/dl ☐ Fasting ☐ Non-fasting

Other _____

Reason for Referral

☐ New dx ☐ hypoglycemia ☐ hyperglycemia

☐ Recent admission ☐ Freq. ER visits ☐ Other_____

_____

Definition of Diabetes (Medicare)

Medicare coverage of DSMT requires the physician to provide documentation of a diagnosis of diabetes based on ONE of the following:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register. Other payers may have other coverage requirements.

Complications/Comorbidities *Check all that apply*

☐ Hypertension
☐ Non-healing wound
☐ PVD
☐ Stroke
☐ Neuropathy/gastroparesis
☐ Mental/affective disorder
☐ Retinopathy
☐ CHD/CAD
Other _____
☐ Kidney disease
☐ Dyslipidemia
☐ Pregnancy
☐ Obesity

I certify that I am the provider treating the participant's diabetes and that DSMT is needed to provide the beneficiary with the skills and knowledge to help self-manage their condition.

Signature and NPI # _____ Date _____/_____/_____

Print Name _____

Group/practice name_____

Group/practice address_____

Phone Number: _____

Provide completed form to patient or fax to: _____