Garro Drugs

704 Bleecker St, Utica NY 13501
Phone: 315-732-6915 Fax: 315-732-6915

INSTRUCTIONS: MEDICARE Part B that all suppliers have Detailed Written order (one per item being prescribed) on file before billing. Please review, sign below and attach all the necessary documents and fax to (315)732-6641

Dear Physician,

Patient: _____ Physician: _____
DOB: _____ _____
MC# _____ _____

Most recent date diabetes control evaluated and charted: _____
1. START date of order: _____
2. DIAGNOSIS: ICD-10-CM _____ Other: ICD-10-CM_____
3. TREATMENT with Insulin Injections: ____ Yes ____ No (If incorrect, please indicate change)
4. Date of Last Face to Face Encounter/office visit for diagnosis above (must be within last six months): _____

5. Description of item ordered: _____ Qty: _____

6. TESTING REGIMEN: ____ One time per day. If other, as specified below.
Items and quantities not to exceed this order and subject to patient's order/actual use and insurer guidelines.

____1 X/day (100 strips & lancets/3 months) ____ 2 X/day (200 strips & lancets/3 months)
____3 X/day (300 strips & lancets/3 months) ____ 4 X/day (400 strips & lancets/3 months)
____5 X/day (450 strips & 500 lancets/3 months) ____ 6 X/day (550 strips & 600 lancets/3 months)
____7 X/day (650 strips & 700 lancets/3 months) ____ 8 X/day (750 strips & 800 lancets/3 months)
____Other _____ times per _____

7. MEDICARE UTILIZATION REQUIREMENT:
For home glucose testing regimens more frequent than 1 X/day for non-insulin patients or 3 X/day for insulin injecting patients, the treating Physician shall see the patient, evaluate their diabetes control and document same approximately every 6 months.
Please provide the documented reason for ordered testing regimen:

____Hypertension ____Fluctuating blood sugar levels ____Adjusting medication
____Other:_____

Medicare requires that chart notes are cosigned by M.D or D.O if ordered by P.A., N.P., or C.N.S

By my signature below I confirm that the patient is/was being treated by me. All the information contained on this order form accurately reflects the patient's condition and the treatment regimen that I have prescribed. For Medicare insurance requirements, I will maintain this signed, original document in the patient's medical record file for post-payment purposes.

PRESCRIBER NAME: _____

SIGNATURE _____ DATE: _____ UPIN: _____ NPI: _____