

**Patient Assessment for Diabetic Testing Supplies and Meter**

Assessor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/19\_\_

HCPCS	Description	Yes/No/comments
A4253	Blood glucose/reagent strips 1 unit = 50 Strips Medicare Allowable is \$38.79 per unit	
A4259	Lancets, box of 100, Medicare Allowable \$12.66	
	Insulin patients are eligible for 100 strips and 100 lancets for a 3 month supply. Non-insulin patients may have 300 lancets and 300 strips for a 3 month supply.	
	Monitor True Result	

Are you being treated by a Physician for your Diabetes? \_\_\_\_ Yes \_\_\_\_ No

Have you been seen by your Physician in the last 6 months? \_\_\_\_ Yes \_\_\_\_ No

When was you're the last date you were seen by your physician? \_\_\_\_/\_\_\_\_/\_\_\_\_

What brand of meter are you currently using? \_\_\_\_\_

What is your Diabetes ICD-9 Diagnosis?

Type 1 – (Insulin Injection Dependent)  Other \_\_\_\_\_

Type 2 – (Pills, Diet and/or Insulin Injection Treated) Other \_\_\_\_\_

2. Insulin Treated?  Yes  No

3. Test Frequency?  1 x/day  2 x/day  3 x/day  4 x/day  Other: \_\_\_\_\_ x/day

If you do not know your diagnosis, please ask your doctor.

For "Other", please include Description: \_\_\_\_\_

Do you have a copy of your latest prescription receipt? Yes \_\_\_\_ No \_\_\_\_ (please obtain copy)

The prescription receipt contains name of patient, the name of the prescription and the prescribing physician, and the amount you paid, it is often stapled to your prescription bag. Provide a copy of receipt if possible:

1. Date of Purchase \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Patient Name Exactly as Spelled on the Receipt:

3. Name of Physician \_\_\_\_\_

4. Amount Paid: \_\_\_\_\_

5. Detail of Purchase \_\_\_\_\_

Does the name on the prescription match the name on your MEDICARE card? Yes \_\_\_\_ No \_\_\_\_

*For example, Nate Smith will not be recognized if recorded at MEDICARE as Nathan Smith. If Names do not match spelling on Medicare Card, please note the different name on the receipt.*

*If the pharmacy or Provider receipt does not have a price, also include the cash register receipt with the items to be reimbursed circled. It is important to note that for your claim to be processed appropriately, we must be able to match up the prescription with the amount paid. If your prescription receipt does not have a price, an itemized cash register receipt is required.*

*Please do not highlight or staple items together.*

**Assignment of Benefits**

I hereby authorize release of any medical or other information necessary for SS MEDICAL SUPPLY to process my request for diabetic supplies and submit claims to my insurer. I also authorize benefit payments to SS MEDICAL SUPPLY. If any insurance company sends payments directly to me for any NDC supplies, I will either forward all checks from my insurance company or write a personal check to SS MEDICAL SUPPLY. I will notify SS MEDICAL SUPPLY immediately of any change in my insurance coverage. I have received and understand Patient Bill of Rights, Privacy Notice, Medicare DMEPOS Supplier Standards, and warranty coverage on the products I have received.

Signature of Patient or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_