BAYLOR
All Saints Medical Center

Diabetes Management Certificate of Medical Necessity

Diabetes Center
p. **817-922-1794**
f. **817-922-1951**

Patient Name: ______________________ Referral Date: ______________
Patient SS#: ______________ Date of Birth: ______________ Daytime Phone: ______________
Address (street, city, state, zip): ______________________ Alternate Phone: ______________
Name of Insurance: ______________________ Insurance Phone: ______________
Subscriber Name (if other than patient): ______________________ Subscriber SS#: ______________
Policy ID#: ____
Is a precert or referral required by the physician's office for this service? ❑ Yes ❑ No
If "yes", please provide precert or referral number: ______________

Diagnosis:

❑ 250.00 Type 2 DM, newly dx
❑ 250.01 Type 1 DM, newly dx
❑ 648.83 Gestational Diabetes
❑ 250.02 Type 2 DM, uncontrolled
❑ 250.03 Type 1 DM, uncontrolled
❑ 790.29 Pre-DM (Other Abnormal Glucose)
❑ 277.7 Dysmetabolic Syndrome
❑ 648.03 Pre-gestational DM
❑ Other (ICD9 code) ______________

Reason for Ordering:

❑ New Onset DM
❑ Inadequate glycemic control
❑ Change in treatment plan
❑ High risk based on one or more of the following conditions:
- ❑ Coronary Artery Disease
- ❑ Hypertension
- ❑ Nephropathy
- ❑ Neuropathy
- ❑ Retinopathy
- ❑ Peripheral Vascular Disease

Management Program:

❑ Type 2 Diabetes/Pre-Diabetes Management (4-6 visits)
❑ Type 1 Diabetes Management (4-6 visits)
- ❑ Center to initiate/titrate insulin per protocol ❑ Physician to initiate/titrate insulin

❑ Gestational Diabetes Management (weekly/bi-weekly until delivery)
❑ Pre-Gestational Diabetes Management (weekly/bi-weekly until delivery)
❑ Ambulatory Insulin Initiation (1-3 visits)
- ❑ Center to initiate/titrate insulin per protocol ❑ Physician to initiate/titrate insulin
- ❑ Discontinue oral agents ______________________________

❑ Adolescent Type 2 Diabetes/Pre-Diabetes Management (5 visits)
❑ Insulin Pump Therapy (6-8 visits)
- ❑ Center to initiate/titrate insulin per protocol ❑ Physician to initiate/titrate insulin

❑ Medical Nutrition Therapy ______________________________
❑ Other: ______________________________

This patient requires individual instruction only because of the following special needs:
❑ Language Barrier: ______________ ❑ Hearing Impairment ❑ Vision Impairment ❑ Other: ______________

Please provide the following (or fax results):

B/P (date __/__): ______________ Wt (date __/__): ______________
FBS (date __/__): ______________ HbA1c (date __/__): ______________ OGTT (date __/__): please fax results
Lipid Panel (date __/__) Chol: ________ LDL: ______ HDL: ______ Tg: ______ Microalbumin (date__/__): ________

Physician Name (please print): ______________________________

Physician Signature: ______________ Telephone: ______________ Fax: ______________

Please fax completed form to: 817-922-1951.

Include recent lab reports, patient information sheet and insurance information.
If you have any questions or need additional information, call the Diabetes Center at 817-922-1794.