An Independent Licensee of the Blue Cross and Blue Shield Association

DIABETES SELF-MANAGEMENT EDUCATION AND MEDICAL NUTRITIONAL THERAPY
330 N. Clyde Morris Blvd., Suite 9, Daytona Beach, FL 32114 Phone (386) 676-7133
FAX orders (along with labs and progress notes) to: (386) 238-3228

Name:_____FHCP # _____

Phone #_____Cell Phone #_____ DOB: _____

DIABETES SELF-MANAGEMENT (DSMT):
(Medicare-10hrs initial DSMT in 12 month period, plus 2 hrs. follow-up annually)
☐Initial DSMT Group (10 hrs.)___# hrs. requested Glucometer Training: ☐Yes ☐No
☐Follow-up DSMT (2 hrs.)_____# hrs. requested CGMS testing (clinic)☐
☐Insulin Start Training: Type of Insulin:_____Amount of Insulin:_____Time(s) _____
☐Patients with special needs requiring individual DSMT training ***(Check all that apply):***
☐Vision ☐Hearing ☐Physical ☐Language Limitations ☐Other_____

DIAGNOSIS:
☐Type 1 Controlled/Uncontrolled ***ICD-10*** _____
☐Type 2 Controlled/Uncontrolled ***ICD-10*** _____
☐Gestational ***ICD-10*** _____

DSMT CONTENT Check education desired ☐**All 10 content areas, as appropriate** or:
☐Monitoring Diabetes
☐Psychological adjustment
☐Nutritional management
☐Goal setting, problem solving
☐Prevent, detect and treat acute complications
☐Diabetes disease process
☐Physical activity
☐Medications
☐Prevent, detect and treat chronic complications
☐Preconception/pregnancy or gestational management

MEDICAL NUTRITION THERAPY (MNT): *Medicare coverage: 3 hrs. initial MNT in the first calendar year, plus 2 hrs. follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.* Check the type of MNT and/or number of additional hours requested:

☐Initial MNT ☐3 hrs or____# hrs requested ☐Annual follow-up MNT ☐2 hrs or____# hrs requested
☐Additional MNT services in the same calendar year, per RD recommendations_____# additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis: _____

NUTRITIONAL COUNSELING: ***ICD-10*** _____
☐Kidney Disease Stages 3-5
☐Eat Right Move Right Adult Weight Management Program
☐Healthy Heart Eating (Lipid)
☐Diabetes Prevention Program (Pre-diabetes)
☐Hypertension
☐Other (specify) _____

Lab Information: ***(Required)*** Glucose:_____A1C:_____Cholesterol:_____HDL:_____LDL: _____

Triglycerides: _____ Weight: _____ Height: _____ BMI: _____

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following: ☐FBS >126 mg/dl x 2 tests ☐Random > 200 mg/dl with symptoms

_____ _____
Physician Name and Provider Number ***Date***