PHYSICIAN'S ORDER AND Rx
(Diabetes Testing Supplies)

Please Fill In #'s 1 thru 6 Sign and Date

ASBURY MEDICAL SUPPLY
6719 N. May Avenue
Oklahoma City, OK 73116
(405) 858-0097 ● Fax (405) 858-0119

PATIENT INFORMATION		
PATIENT NAME:		DATE OF BIRTH:
ADDRESS:	CITY, STATE, ZIP:	
PHONE:	OTHER CONTACT (Name and Number):	

INSURANCE INFORMATION		
PLEASE SEND A COPY OF INSURANCE CARDS (If Available)		
PRIMARY INSURANCE:	POLICY NUMBER (Primary):	PHONE (Primary):
SECONDARY INSURANCE:	POLICY NUMBER (2nd):	PHONE (2nd):

Asbury Medical Supply will supply the patient with a new monitor, test strips, lancets, lancet device, and control solution.

1) ☐ YES ☐ NO I have evaluated this patient withing the last 6 months and concluded he/she is capable of following instructions for controlling their diabetes and is able to use the prescribed testing items.

2) ☐ YES ☐ NO Is this patient currently using INSULIN INJECTIONS to control their Diabetes?

3) ☐ YES ☐ NO Is your patient's vision impaired enough to require a voice synthesizer? If yes, indicate the level of impairment.

4) ☐ YES ☐ NO Is the patient in need of a glucometer?

5) **TEST FREQUENCY**. Test strips & lancets prescribed for a 90 day period.

☐ 1 x day = 100 ☐ 3 x day = 300 ☐ 5 x day = 500
☐ 2 x day = 200 ☐ 4 x day = 400 ☐ 6 x day = 550 ☐ Other_____

6) **DIAGNOSIS.**

☐ Insulin
- ☐ 250.01
- ☐ 250.03 uncontrolled

☐ Non-Insulin
- ☐ 250.00
- ☐ 250.02 uncontrolled

If patient is using insulin and TEST's MORE than 3 times per day, Medicare requires a written explanation as to why:

If patient is NOT using insulin and TEST's MORE than 1 time per day, Medicare requires a written explanation as to why:

PHYSICIAN'S EXPLANATION:

PHYSICIAN INFORMATION		
Physician Name:		UPIN #:
Address:	City, State, Zip:	
Phone Number:	Fax Number:	

PHYSICIAN'S SIGNATURE:	**DATE:**

PLEASE FAX TO ASBURY MEDICAL SUPPLY (405) 858-0119