Edgepark is the nationwide leader in home-delivered medical supplies for diabetes, ostomy, wound care, urological, incontinence and more. We are contracted with more than 1,000 private insurance plans and accept Medicare assignment on most items.

Lake County Physicians (REF CODE: LCPII)

TO:  Cynthia Gessler
FROM:  LAKE COUNTY PHYSICIANS
COMPANY:  Edgarpark Medical Supplies
FAX NUMBER:  614.652.8547
PHONE NUMBER:  800.321.0591 ext 3141
Re:  
E-MAIL:  cynthia.gessler@edgarpark.com

Internal use only referral code: LCPII
Please use referral code LCPII for Physicians group reporting

You have the right not to receive any future faxes or fax advisories from Edgepark Medical Supplies. You may exercise this right by calling 1-800-321-0591 or by faxing your removal request to 1-877-803-9994 twenty-four hours a day, seven days a week. Our failure to comply with your request within 30 days, or the shortest reasonable time as determined by the Federal Communications Commission (FCC), would be unlawful.

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Physician's Written Order
Glucosemeter and Diabetes Testing Supplies

Start Date ______ / ______ / ______

All fields are required to process an order.

Patient Information

First: ___________________________ Last: ___________________________

Address: _______________________________________________________

City: ___________________________ State: __________ ZIP: __________

Phone #: ________________________ E-mail Address: __________________

Physician Name ___________________________ NPI #: __________

Address: _______________________________________________________

City: ___________________________ State: __________ Zip: __________

Phone: ______________________ Fax: __________________

Primary Insurance:

Policy/ID #: ______________________

Group #: ______________________

Phone #: ______________________

Secondary Insurance:

Policy/ID #: ______________________

Group #: ______________________

Phone #: ______________________

Type 1 Diabetes

☐ 10.9 No Complications

☐ 11.0 With Complications (specified)

☐ 11.0 With Hyperglycemia (uncontrolled)

☐ 10.64 Hypoglycemia Without Coma

☐ Other:

Type 2 Diabetes

☐ 11.9 No Complications

☐ 11.8 With Complications (specified)

☐ 11.8 With Hyperglycemia (uncontrolled)

☐ 10.649 Hypoglycemia Without Coma

☐ E11.649 Hypoglycemia Without Coma

☐ Other:

Gestational Diabetes

☐ 014.141 Insulin-Controlled

☐ 099.810 Abnormal Glucose (tolerance)

☐ 024.410 Diet-Controlled

☐ EDD ______ / ______ / ______

☐ Other:

Quantity to dispense of strips, lancets and alcohol wipes per 90 days. (**Based on patient’s frequency of use/times testing per day.)

☐ 1x/day - 100

☐ 2x/day - 200

☐ 3x/day - 300

☐ 4x/day - 400

☐ 5x/day - 450

Times Testing: ______ x Testing Per Day

Is the patient currently being treated with daily insulin injections?

☐ Yes ______

☐ No ______

X Injecting Per Day

Is the patient currently on insulin pump therapy?

☐ Yes ______

☐ No ______

Estimated duration of need: ______ months (99 = Lifetime)

Has the patient been seen and had his or her diabetes evaluated in the last six months?

☐ Yes ______

☐ No ______

Medicare Exceeded Limit Guidelines:

If patient's testing exceeds Medicare guidelines (greater than 1x/day non-insulin-treated or 3x/day insulin-treated testing), please complete the following:

I have documented in the patient's medical record the times testing and the reason(s) for high testing as:

☐ Fluctuating Blood Sugar

☐ Poor Glycemic Control

☐ Other ___________________________

Dispense the Following Supplies (per 90 days):

☐ Blood Glucose Monitor (E0607) qty 1

Preferred Meter

☐ Syringes (A4206 or S8490)*

Size: ______

Gauge: ______

cc: ______

(1 unit per injection)

☐ Pen Needles (A4215)*

Size: ______

Gauge: ______

cc: ______

(1 unit per injection)

*Times Injecting Daily

☐ Replacement Battery for Monitor (A4233 or A4235) - qty. 2

☐ Lancasting Device (A4258) - qty. 1/180 days

☐ Ketone Strips - qty. 90/90 days

☐ Urine (A4250)

☐ Blood (A4252)

☐ Control Solution (A4256) qty

☐ Alcohol Wipes (A4425)**

☐ Test Strips (A4253)**

☐ Other ___________________________

**Quantity to dispense based on patient's times testing daily

I certify that I am the physician/practitioner identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature: ___________________________

(Stamps are not acceptable)

Date: ______ / ______ / ______

Printed Name: ______________

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