Oneida Healthcare
EXCEPTIONAL CARE ... ALWAYS

Certificate of Medical Necessity for Diabetes Self-Management Training

THIS SECTION MUST BE COMPLETED:

- ☐ **Please include patient's current medication list.**
- ☐ **Dietary Consult Only**
- ☐ **Diabetes Class Series (Includes Dietary Consult & Accu-Chek BG both days)**
- ☐ **Insulin Instruction/Glucometer Instruction**

Insurance Authorization #_____
Date of Insurance Authorization_____

Patient Name		**D.O.B.:**
Address:		**Date:**
City and State	**Zip Code**	**Daytime phone:**
Health Ins.	**SS#:**	**Policy/ID#:**

As the health care provider treating this beneficiary's diabetic condition, I certify that diabetes self-management training is needed under a comprehensive plan for this patient's diabetes care to ensure therapy compliance and/or to provide the necessary skills and knowledge to enable the patient to manage his/her condition.

REASON FOR ORDERING TRAINING

☐ New onset diabetes (diagnosed within last 12 months).

☐ Inadequate glycemic control, indicated by:
- ☐ Two HbA1c ≥ 8.6% within last three months. #1 HbA1c & date_____ #2 HbA1c & date_____
- ☐ Documented acute episodes of severe hypoglycemia or acute hyperglycemia occurring in the past year, during which the patient needed emergency room visits or hospitalization.

☐ Change in condition/treatment regimen:
- ☐ From no diabetes medication to any diabetes medication.
- ☐ From oral diabetes medication to insulin.
- ☐ Other _____

☐ High risk based on one or more of the following documented complications:
- ☐ Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation.
- ☐ Pre-proliferative or proliferative retinopathy or prior laser treatment of eye.
- ☐ Kidney complications related to diabetes when manifested by albuminuria or elevated creatinine

TRAINING ORDERED

Only through a program of diabetes self-management training can the patient acquire the necessary skills and knowledge to comply with the treatment plan. The following specific training is ordered (describe):

☐ Initial training _____

☐ Follow-up training _____

☐ This patient cannot effectively participate in group instruction because of the following special needs:
- ☐ Language barrier _____ ☐ Impaired vision/hearing _____
- ☐ No class starting within 2 months ☐ Other _____

DIAGNOSIS AND TREATMENT

☐ E11.9 type2 ☐ E10.9 type 1 ☐ E11.65 type 2, uncontrolled ☐ E10.65 type 1, uncontrolled
☐ Gestational diabetes ☐ Diabetes with pregnancy ☐ Other _____

Diabetes treated with: ☐ Diet only ☐ Oral medication ☐ Insulin ☐ Insulin Pump

FREQUENCY OF TESTING

☐ Daily ☐ 2 times a day ☐ 3 times a day ☐ 4 times a day ☐ Other_____

DOCUMENTATION

Variability of blood glucose values (provide range): _____% of time out of range_____
HbA1c_____% (normal range_____)
Comorbidities: ☐ Hypertension ☐ Peripheral vascular disease ☐ Neuropathy ☐ Visual impairment
☐ Dyslipidemia ☐ ESRD ☐ Other_____

Complicating/aggravating circumstances: ☐ Hospitalizations: Last date admitted:_____
☐ Other_____

SIGNATURE MUST BE HAND SIGNED – STAMPED SIGNATURE NOT ACCEPTABLE

Physician's signature:_____ Date_____Time: _____

Physician's name (printed) _____ Phone:_(_____)_____

Office navigator: _____ Phone: (_____)_____

Address:_____

City:_____ State:_____ Zip:_____

EDM (00541) Diab Cert of Med Necessity
Rev: 9/01; 3/03/12/06, 12/14, 9/15, 12/15, 4/16, 3/17

diacermednec

Please fax to Patient Scheduling
315-361-2271