DEXCOM ORDER FORM
Certificate of Medical Necessity

For easier processing, please use blue or black ink and use block lettering.

SECTION A: Patient and Prescriber Information

PATIENT INFORMATION

Patient Gender M ☐ F ☐ Height _____ (in.) Weight _____ (lbs.)

Patient Name		Date of Birth
Patient Address		
City	State	Zip
Primary Phone	Patient Email Address	
Dexcom Patient # (for Dexcom use only)	English is my primary language: Yes ☐ No ☐	

PROVIDER INFORMATION

Provider Name		
Provider Address		
City	State	Zip
Primary Phone	Fax	
Check one: ☐ NPI # (Required) ☐ DEA # ☐ State License #		

SECTION B: Information in this Section may not be Completed by the Supplier of the Items

DIAGNOSIS CODE: ICD-10 Code (Check box) ☐ E10.65 ☐ E10.9 ☐ E11.9 ☐ O24.41(for G7 only) ☐ Other _____

STATEMENT OF MEDICAL NECESSITY

Currently on CGM ☐ Yes ☐ No A1C _____ Fasting Hyperglycemia _____ mg/dL

On Insulin Pump ☐ Yes ☐ No #Fingersticks _____ per day #Injections _____ per day Fluctuating of BG Level Low _____ mg/dL High _____ mg/dL

CLINICAL CONSIDERATIONS (Check all that apply)

- ☐ A. Patient is on insulin therapy
- ☐ B. Patient administers 3+ injections per day or on an insulin pump
- ☐ C. Patient self checks BG 4+ times per day
- ☐ D. Patient's insulin treatment requires frequent adjustment by patient on the basis of BGM or CGM testing results.
- ☐ E. History of hypoglycemia unawareness, severe hypoglycemia resulting in third party intervention and/or hospitalization/ paramedical treatment.
- ☐ F. Within 6 months prior to ordering CGM, patient had in-person visit with treating practitioner to confirm that patient is diabetic and meets A-E above and to evaluate patient's diabetes control.
- ☐ G. Patient is motivated and knowledgeable to use CGM, and adheres to a diabetes treatment plan.

PRIMARY/SECONDARY INSURANCE

(or include front and back of patient's insurance card) Policy Holder Gender M ☐ F ☐

Insurance Name	Policy Holder Name	Policy Holder DOB
Plan Phone Number	Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	
ID Number	Rx BIN	
Group Number	Rx PCN	
☐ **Medicare Member ID#**		

SECTION C: Prescription Information

			QUANTITY	REFILLS
Dexcom G6 Receiver	☐ 1 Receiver NDC: 08627-0091-11 A9278, K0554, E2103	SIG: Use to monitor blood glucose. Displays glucose trends in 3 colors when glucose is high, low or within range.		
Dexcom G6 Transmitter	☐ 1 Transmitter NDC: 08627-0016-01 A9277, K0553, A4239	SIG: Change transmitter every 3 months. Fastened on top of the sensor and wirelessly sends data to the receiver or compatible smart device. For therapeutic CGM, include all necessary supplies and accessories.		
Dexcom G6 Sensors	☐ 1 three-pack Sensors NDC: 08627-0053-03 A9276, K0553, A4239	SIG: Change sensor every 10 days. Discreetly worn under clothing and measures glucose levels under skin. For therapeutic CGM, include all necessary supplies and accessories.		
Dexcom G7 Receiver	☐ 1 Receiver NDC: 08627-0078-01 A9278, K0554, E2103	SIG: Use to monitor blood glucose. Displays glucose trends in 3 colors when glucose is high, low or within range.		
Dexcom G7 Sensor	☐ 1 one-pack 10-day sensor with Integrated Transmitter NDC: 08627-0077-01 A9276, A9277, K0553, A4239	SIG: Change sensor with integrated transmitter wearable every 10 days. Quantity 1 = 10-day supply; Quantity 3 = 30-day supply; Quantity 9 = 90 day		

Last office visit: _____ **Order date:** _____

PLEASE COMPLETE THE PRESCRIPTION INFORMATION ACCORDING TO STATE RULES & REGULATIONS

This document serves as prescription and statement of medical necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring System (New/Replacement Sensors, Transmitters, and Receivers) and all associated diabetes supplies to be provided by Dexcom or authorized designee.

I certify that I am the prescriber identified in the above section and the medical necessity information contained in this document is true, accurate/complete to the best of my knowledge.

Provider/Authorization Signature: _____ Date _____

Substitution Permitted

In Order for a brand name product to be dispensed, the prescriber must hand write "Brand Necessary" or "Brand Medically Necessary" in the space below

_____

Brand Medically Necessary

Dexcom, Inc.
6340 Sequence Drive, San Diego, CA 92121

Dexcom

DEXCOM ORDER FORM

Assignment of Benefits

Dexcom, Inc., and third-party distributors that may be assisting you, including product distributors and pharmacies (collectively, “Distributors”) recognize that medical information is confidential and will maintain the privacy of your medical information. Your medical information will only be used and disclosed in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your signature below authorizes Dexcom to obtain medical information from your healthcare providers.

Many insurance companies require that medical information be submitted with claims to determine medical necessity. By signing below, you authorize Dexcom or the Distributors to submit claims directly to your insurance company to make payments directly to Dexcom or the Distributors. You also understand that you are responsible for any deductibles, co-payments, and other amounts not covered by your insurance. Dexcom or the Distributors, whichever party is processing the claim, will make every reasonable effort to collect payment from your insurance company. In the event your insurance company does not accept an assignment of benefits or pay for services rendered, you agree that you will be responsible for the full amount of the claims associated with acquiring a Dexcom product. You also consent to the release of all information, including medical records to or from your health care provider and/or their representatives, your insurance company, Dexcom or the Distributors, for the purposes of healthcare management and/or processing claims.

Patient signature _____ Date _____

Patient name (please print) _____ Patient’s Date of Birth _____

Parent/Guardian signature _____ Parent/Guardian printed name _____ Date _____

Provider name _____

CMN Form LBL-1003003 for use in the following states: Alaska, Arizona, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Maine, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Wisconsin.

Dexcom, Inc.
6340 Sequence Drive, San Diego, CA 92121

NPI # 1235312695