



# Patient Referral Form WITH PHYSICIAN'S ORDER

1198 Buckhead Crossing  
Suite B  
Atlanta, GA 30189  
1-800-214-2212

Date \_\_\_\_\_ Rep Initial \_\_\_\_\_

Fax form with patient's and physician's signature to 1-800-782-0504

## PATIENT INFORMATION *(Please print)*

Name \_\_\_\_\_ Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
DOB \_\_\_\_\_  M  F Atl. Contact Name \_\_\_\_\_

### Authorization to Process Insurance Claims

I authorize the release of any medical or other information necessary for Serenity Medical LLC to process and submit all past, present and future claims to Medicare and/or my insurer, effective the date of this signature. I want to be part of the Serenity Medical LLC program and authorize someone from Serenity Medical LLC to contact me to coordinate/arrange delivery of my supplies. I understand that my insurer and/or Medicare may impose co-payments or deductibles for which I am responsible. If I have any questions about the amounts I am responsible for I can contact my insurance company. I also authorize payment of Medicare and/or insurance benefits to Serenity Medical LLC for the services and supplies I receive from Serenity Medical LLC. I acknowledge that I have received a copy of Serenity Medical LLC Practices, the Patient Supplies and Supplier Standards and the supplies indicated below. If my account goes into collection I will be responsible for any attorney fees, court cost, and collection fees. This authorization is in effect until I revoke it in writing.

Date \_\_\_\_\_ Patient Signature \_\_\_\_\_  
Atl. Contact Phone \_\_\_\_\_

Referral Name \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

## INSURANCE INFORMATION *Complete if available OR fax a copy of the front and back of the patient's insurance card with this form.*

Medicare/Medicaid # \_\_\_\_\_  
Other Ins.# \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy # \_\_\_\_\_ Group ID # \_\_\_\_\_  
Policyholder's Name (if other than pt.) \_\_\_\_\_

1. Which Meter was given or patient currently uses \_\_\_\_\_
2. Testing Frequency: \_\_\_\_\_ times/day
3. Duration of need  99. lifetime  Other
4. Using Insulin to control/treat  Yes  No
5. Date last supplies received \_\_\_\_\_

## *Must be completed by Physician*

### DIABETES ICD-9 DIAGNOSIS

- 250.01 Type I (juvenile type), not stated as uncontrolled
- 250.03 Type I (juvenile type), **uncontrolled**
- 250.00 Type II (unspecified type), not stated as uncontrolled
- 250.02 Type II (unspecified type), **uncontrolled**
- 369.00 Legally Blind (also check 250.01 or 250.00) \_\_\_\_\_
- 648.8 Gestational Diabetes EDC / /
- Other

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICARE UTILIZATION GUIDELINES:

Medicare allows for 1x/day or less non-insulin treated or 3x/day or less insulin treated testing.

**If patient's testing exceeds Medicare guideline, please complete the following:**

1. Has the patient been seen in the last six months?  Y  N  
*If yes, please include/send Doctors Narrative and/or Lab results (HbA1C) per Medicare Payment Guidelines.*
2. I have documented in the patient's medical record the times testing and the reason(s) for high testing as:
  - Fluctuating Blood Sugar  Hypoglycemia
  - Hypertension  Uncontrolled Blood Sugar
  - Other \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_ NPI # \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

My signature below denotes to the best of my knowledge the patient/caregiver is capable of using the test results for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/caregiver has successfully completed training or is scheduled to begin training in the use of the monitor and supplies.

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE STAMPS ARE **NOT** ACCEPTABLE

For additional information call us at 800-214-2212 or visit [www.serenitymedical.com](http://www.serenitymedical.com)

This is a confidential message. It is intended solely for the person to whom it is addressed. It must be kept in strict confidence. If you receive this message in error, please forward it by fax to (800) 782-0504. Thank You.