2195 Harrodsburg Road, Suite 125, Lexington, KY 40504 859-323-2232, option 3

Diabetes Prevention Program Certificate of Medical Necessity (Patient Order Form)

Referral from: Physician Name: ______________________ Fax #: _____________________

Patient Data: Name: ____

DOB: _________________ Social Security #: ______________________________________

Address: ____

Primary Phone #: ___________________________ Other Phone#: _________________________

Insurance Type______________________ **(PLEASE INCLUDE COPY OF PATIENT'S INSURANCE CARD)**

____ Please mark if patient has no insurance and is self-pay

RX: Please write current ICD-10 diagnoses here__________________ or, select from the list below by marking the line with a "X":

Diagnosis

____ R73.09 Prediabetes (abnormal fasting glucose)
____ R73.02 Prediabetes (Impaired glucose tolerance)

Patients with special needs requiring individual instruction
Please mark all that apply:
___Vision ___Hearing ____Physical _____Cognitive Impairment
___Language Limitations (Interpreter Needed-specify language needed) ________________________________
___Other: _________________________

DPP Eligibility Criteria: Must provide one of the Prediabetes Diagnostic Criteria:

FBG$\geq$ 100mg/dL to $\leq$ 125mg/dL BG: ________ Date: ___________

2-hour OGTT $\geq$ 140-199mg/dL 2 hr OGTT (75 grams) BG: _________

Date: _____________

A1C (5.7% to 6.4%) A1C:_________ Date:____________

Please verify the following information:

__ No history of Diabetes (Type 1 or Type 2)

Yes or No $\geq$ 18 years of age

Yes or No BMI $\geq$ 25kg or $\geq$ 23mg if Asian

Yes or No Patient is NOT pregnant

Yes or No History of Gestational Diabetes Mellitus

SIGNATURE REQUIRED MD/DO/APRN/PA: ____________________________________ DATE: ______________

PLEASE FAX COMPLETED FORM TO 859-257-0659