RICK'S MEDICAL SUPPLY

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DURABLE MEDICAL EQUIPMENT PRESCRIPTION

IF MEMBER HAS BEEN APPROVED FOR A CGM, THEY DO NOT QUALIFY FOR MANUAL TESTING SUPPLIES

NAME:_____ **DOB:**_____

ADDRESS:_____ **PHONE:**_____

ICD-10 Code:_____ **(Required)** **LENGTH OF NEED:**_____**Months (Required)**

DIABETIC SUPPLIES: ***Submit Chart Notes, Current A1C Labs, Review of Blood Sugar Levels, and Current Medication List with Dosing with Each Request.***

MEMBER IS TO TEST:_____**PER DAY** **INSULIN INJECTIONS:** _____**PER DAY**

***TEST STRIPS 50/box**	Qty/month:
***LANCETS 100/box**	Qty/month:
***ALCOHOL WIPES 100/box (For testing)**	Qty/month:
***PEN NEEDLES 100/box (For use with INSULIN PENS ONLY) (BE SPECIFIC)**	Qty/day:
***INSULIN SYRINGES W/NEEDLES 100/box (For use with INSULIN VIALS ONLY) (BE SPECIFIC)**	Qty/day:

INCONTINENT SUPPLIES

***BRIEFS (Tape-on) - SZ:**_____**QTY:**_____ **PULLUPS (Underwear) - SZ:**_____**QTY:**_____ **LINERS-QTY:**_____ **(ANY COMBO 200 MAX PER MONTH)**
***DISPOSABLE UNDERPADS (Chux) (100 Max Per Month) Qty:** _____ **OR** **WASHABLE UNDERPADS (8 Max Per Year) Qty:** _____
***GLOVES (2 Boxes Max Per Month) - QTY SM:**_____ **QTY MED:**_____ **QTY LG:**_____

MISC SUPPLY (Check supply)

***NEBULIZER (1 Every 5 Years Max) – QTY:**
***NEBULIZER MASK (1 Per Month Max) – QTY:**
***DISPOSABLE NEBULIZER CUP KIT (2 Per Month Max) – QTY:**
***SPACER:**
***PEAK FLOW METER:**
***AUTOMATIC BLOOD PRESSURE MONITOR:** _____ **CUFF SIZE:** ☐ **Pediatric** ☐ **Regular** ☐ **Bariatric**

PRESCRIBING PHYSICIAN (Print): _____ **Fax# (Required):**_____

SIGNATURE: _____ **DATE (Required):**_____