Phone: 313-874-9427
OR 1-855-759-7927
Fax: 313-874-9515

HFPN – Diabetes Care Centers (DCC)
Certificate of Medical Necessity for Diabetes Self-Management Education (DSME)
** Please complete and fax WITH INSURANCE FACE SHEET to 313-874-9515 Attn: DCC **

Patient Last Name:	**First Name:**	**Patient Phone:**	**DOB:**
Patient's Address:		**City:**	**Zip:**
Physician:		**Physician Phone #:**	
Physician Address:		**Physician Fax#:**	

Prefer email correspondence and have a hospital-based Outlook account? If yes to both, please add email address below.

Physician Email:_____

Please Select Diagnosis

New Onset Diabetes	Inadequate Glycemic Control	**Diabetes Complications Present: (Please specify with ICD-9 code)**
___ 250.00 Type 2		
___ 250.01 Type 1	___ 250.02 Uncontrolled Type 2, w/o Oral Meds	
___ 790.29 (With IFG/IGT)**(MNT only)**	___ 250.02 Uncontrolled Type 2, with Oral Meds	
___ 648.03 Pregnancy with DM known	___ 250.02 Uncontrolled Type 2, with Insulin	
___ 648.83 Gestational DM	___ 250.03 Uncontrolled Type 1	

Physician Prescription

TYPE 1 and TYPE 2 Diabetes Education Ordered:

___ Full DSME Program = 1 hour Individual Diabetes Assessment (G0108) and 9 hours Group Training (G0109)
Include 1 hour Medical Nutrition Therapy * (individualized meal plan and nutrition education) (97802)
OR
___ Full DSME Program = 1 hour Individual Diabetes Assessment (G0108) and 9 hours Individual Training (G0108)
1:1 Due to Education Barriers
Please check specific barrier(s) ___ Impaired Hearing ___ Impaired Vision ___ Impaired Cognition ___ Low Literacy ___ Language, Limited English Skills
___ Follow-Up DSME (Previously received Diabetes Education)
___ Follow-Up DSME (Medicare beneficiaries) = 2 hours maximum Individual or Group Training per year
___ ONLY Medical Nutrition Therapy (MNT) * **(*Medicare benefit allowed in addition to full DSME)**

___ Gestational Diabetes Class = 3 hour Group Instruction

Please list all prescribed **diabetes** medications with dose **OR attach** a print out of e-Prescribing/current medicine summary:

LABS must be provided (Please attach a set of most recent labs including specific labs requested below if able.)
TYPE 1 and TYPE 2 Diabetes Patients

Height **Weight** | **Blood Pressure**

Test	**Date of Test**		**Test Result**		**Test**	**Date of Test**	**Test Result**
HbA1c (or FPG*)					**Total Cholesterol**		
Triglycerides					**HDL-Cholesterol**		
*Fasting Plasma Glucose ≥126 mg/dl	#1	#2	#1	#2	**LDL-Cholesterol**		

I certify that I am managing the diabetic condition of the above mentioned patient and the training described in this plan of care is needed to ensure therapy compliance or to provide this patient with the necessary skills and knowledge to help manage his/her diabetes.

Physician's Name (Please Print):	**Date:**
Physician's Signature:	**UPIN:**