HUNTSVILLE HOSPITAL

THE DIABETES CONTROL CENTER

Appointment Date_____
Time_____

420 Lowell Drive • Suite 500 • Huntsville, Alabama 35801 • Phone 256-265-3069 • Fax 256-265-3073
Physicians please call Central Scheduling to schedule • 256-265-4321 Patients may call 256-265-9999 Toll Free 1-800-510-0736

Certificate of Medical Necessity for Diabetes Self-Management Training

Patient name:		SS #:
Patient address:		Phone #:
City:	State:	Zip:
Insurance:	Group #:	DOB:

NEED FOR DIABETES SELF MANAGEMENT TRAINING

I certify that diabetes self-management training services are needed under a comprehensive plan for this patient's diabetes care.

Reason for ordering diabetes self-management training:

☐ Newly diagnosed 10hrs. ☐ Change in condition/treatment regimen_____

☐ Group instruction: 10hrs. ☐ Individual instruction: 2hrs per calendar year

Reason for individual instruction: ☐ Language ☐ Impaired hearing/sight ☐ Other_____

DIAGNOSIS

☐ E11.65 Type 2 diabetes mellitus with hyperglycemia ☐ E10.65 Type 1 diabetes mellitus with hyperglycemia

Other_____

Is the patient treated with insulin? ☐ Yes ☐ No Using an insulin pump? ☐ Yes ☐ No

Is the patient treated with oral agents? ☐ Yes ☐ No

Comments_____

☐ Diet order_____ ☐ Dietitian to determine calorie needs

FREQUENCY OF MONITORING

☐ Daily ☐ 2 times a day ☐ 3 times a day ☐ 4 times a day ☐ Other _____

Comorbidities:

☐ Hypertension ☐ Periphperal vascular disease

☐ Dyslipidemia ☐ Neuropathy

☐ Other_____

Lab Results

☐ Microalbumin_____ Date_____

☐ Serum creatinine____ Date_____

☐ Hemoglobin _____ Date_____

A1C _____ Date of test _____

Physician signature and printed name required by medical records

Physician's signature: _____ Date: _____Time:_____

Physician's name (printed): _____ Phone #: _____

Address: _____ Fax #: _____

City: _____ State: _____ Zip: _____