Form # 2535 (07/21)

MUNSON HEALTHCARE

2535

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING AND MEDICAL NUTRITION THERAPY REFERRAL FORM

Patient's Legal Name: _____
LAST FIRST MIDDLE

Date of Birth: _____/_____/_____ Phone #: _____ Other Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____

Insurance: _____ Prior Auth. #: _____

DIABETES DIAGNOSIS — ICD-10

- ☐ Type 1 Diabetes E10.9
- ☐ Type 2 Diabetes E11.9
- ☐ Gestational Diabetes O24.419
- ☐ Pre-existing Type 1 Diabetes in pregnancy O24.019
- ☐ Pre-existing Type 2 Diabetes in pregnancy O24.119
- ☐ Pre-diabetes R73.03

Diabetes self-management education/training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

LAB ELIGIBILITY

Medicare requires verification of diabetes diagnosis by one of the following for type 1 and type 2 diabetes:

- ☐ FBG > 126 mg/dl on 2 tests:
  FBG: _____ and FBG: _____
- ☐ 2 hr OGTT > 200 mg/dl on 2 tests:
  2 hr OGTT: _____ and 2 hr OGTT: _____
- ☐ Random BG > 200 mg/dl with symptoms of uncontrolled diabetes: Random BG: _____

Other Labs: ☐ **See Power Chart**

- ☐ HgbA1C: _____ % Date: _____

DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T)

Medicare coverage: 10 hours initial and 2 hours each year thereafter

The patient is to attend the following:

- ☐ Initial Diabetes Self-Management Training (10 hours) ☐ _____ hours requested
  Includes all ten content areas, as appropriate, based on assessment
- ☐ Annual Update (2 hours) ☐ _____ hours requested

This patient cannot effectively participate in group instruction because of the following special needs:

- ☐ Physical ☐ Language limitation ☐ Cognitive impairment
- ☐ Hearing/Vision ☐ Learning disability ☐ Other: _____

MEDICAL NUTRITIONAL THERAPY (MNT)

Medicare requires signature of an MD or DO for MNT

- ☐ Initial MNT
  ☐ 3 hours ☐ _____ hours
- ☐ Annual follow-up
  ☐ 2 hours ☐ _____ hours
- ☐ Additional reinforcement of nutrition in the same calendar year per RD
  ☐ _____ hours requested

Additional Self-Management Training Request

- ☐ Pre-diabetes Group *(1 time class)*
- ☐ Diabetes Prevention Program as available *(12 month program)*
- ☐ GDM Class or ☐ Pre-existing Diabetes in Pregnancy Class
- ☐ Additional Insulin Training (1:1) *Complete Insulin Instruction Checklist, form #10934*
- ☐ Pump Assessment/Start-up ☐ Pump Upgrade
- ☐ Pump w/ Sensor Training ☐ Sensor Training
- ☐ Professional Continuous Glucose Monitor
- ☐ Injection Therapy Education *GLP / Other:* _____
- ☐ Kalkaska Medical Associates DM Clinic

SPECIFIC INSTRUCTIONS

_____

_____

_____

_____

_____

_____
PROVIDER SIGNATURE

_____
DATE

_____
TIME

Provider's Printed Name: _____ NPI #: _____

Practice Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT ID LABEL HERE

MMC Diabetes Education
P: 231-935-8200 | F: 231-935-8215

KMHC Diabetes Education
P: 231-258-3091 | F: 231-392-7347

POMH Diabetes Education
P: 231-935-8200 | F: 231-935-8215

OMH Diabetes Education
P: 989-731-7872 | F: 989-731-7837