nazareno DIABETES
(787) 740-2934

SUPPLIES PRESCRITION ORDER

Dexcom
TANDEM DIABETES CARE

PATIENT ORDER INFORMATION			
NAME:		DATE	
ADDRESS	CITY:	State: P.R.	Zip Code:
Diagnosis Code/ICD-10 Code ☐ E10.65 ☐ E10.9 ☐ E11.9 ☐ E11.65 Other:			

TANDEM T: SLIM X2 INSULIN PUMP SUPPLIES

(A) Infusion Set model:

☐ AUTOSOFT 30
30-degree cannula

☐ TRUSTEEL ™
90-degree stainless steel needle

☐ AUTOSOFT 90
90–degree cannula

☐ AUTOSOFT™ XC
90-degree cannula

(B) Infusion set change frequency: ☐ Every 3 day (Qty.30) ☐ Every 2 day (Qty.50)

(C) 300ml Cartridge change frequency: ☐ Every 3 day (Qty.30) ☐ Every 2 day (Qty.50)

(D) Refill times _____

DEXCOM G6 CGM SUPPLIES

☐ A9276 Sensors; Quantity 3 boxes
Directions for use: Site change per manufacturer recommendations, up to 90-day supply unless otherwise noted;

☐ A9277 Transmitter – (3-month use) Sig: Dispense 2 / 1 Refill
Use per Manufacturer instructions

Refill times _____

MEDICARE

☐ K0553 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1-month supply = 1 unit of service

PHYSICIAN INFORMATION	
Physician Name:	Phone #:

I certify that I am the prescribing provider identified above and have reviewed all of the order information above. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify all the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of the products marked above. I understand the indications for use and associated warnings and precautions of the products I have prescribed here in. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician Signature X	PR Lic #	NPI #
VITAL PCP Signature (if apply) X	PR Lic #	NPI #

Please send completed to: ***suplidos@nazarenollc.com*** or fax to (787) 288-0704