



Diabetic Service Foundation

Pharmacy Order Form For Diabetic Supplies

4820 Park Blvd Pinellas Park, FL 33781

Local Phone: 727.545.4288 Local Fax: 727.544.8530

Toll Free Phone: 1-800-244-1133 Toll Free Fax: 1-800-289-8230

www.servicetodiabetics.com

To receive information only,

Simply call our toll free number or fill in your name, address and phone number, and send by mail or fax

To sign up to receive your supplies delivered to your door,

Simply call our toll free number or fill out and sign the top portion of this form and have your physician fill out and sign the bottom portion and send by mail or fax

Patient Name: _____					<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Spanish Speaking Only	
Address: _____										
City: _____			State: _____			Zip: _____				
Date Of Birth: _____					Medicare ID #: _____					
Day Time Phone: () _____					Evening Phone: () _____					
Secondary Insurance: _____					Policy Number _____					
I hereby authorize the physician listed below, to release any medical information or records pertaining to my diabetic condition to Diabetic Service Foundation and give Diabetic Service Foundation permission to bill Medicare and/or my co-insurance on my behalf.										
Patient Signature: _____					Date: _____					
Physicians, Please Fill Out Completely and Sign The Bottom Portion Of This Form And Fax It To The Toll Free Number Below										
<input type="checkbox"/> Patient Requires a New Monitor <input type="checkbox"/> Patient Has Monitor Monitor Type Already Using: _____										
<input type="checkbox"/> Patient or caregiver has successfully completed training or is scheduled to begin training in the use of the monitor and supplies.										
<input type="checkbox"/> Patient or caregiver is able to use blood glucose results to help control patients diabetes.										
<input type="checkbox"/> Patient has severe visual impairment (20/200 or worse) that requires the use of an audio response based specially designed meter.										
<input type="checkbox"/> I have seen this patient and evaluated his/her diabetes control within the last 6 months.										
Supplies needed for Blood Glucose Testing: <input type="checkbox"/> Initial Home Use Glucose Monitor <input type="checkbox"/> Replacement Monitor, if needed <input type="checkbox"/> Testing Strips <input type="checkbox"/> Lancets										
Frequency of Testing		<input type="checkbox"/> 1 time a day		<input type="checkbox"/> 2 times a day		<input type="checkbox"/> 3 times a day		<input type="checkbox"/> 4 times a day		<input type="checkbox"/> Other _____
Is Patient Insulin Dependant <input type="checkbox"/> YES <input type="checkbox"/> NO										
Diagnosis		<input type="checkbox"/> 250.00 Type 2 Controlled		<input type="checkbox"/> 250.02 Type 2 Uncontrolled		<input type="checkbox"/> 250.01 Type 1 Controlled		<input type="checkbox"/> 250.03 Type 1 Uncontrolled		<input type="checkbox"/> Other _____
Physician Information										
Physician Name: (printed) _____										
Street Address _____				City _____			State _____		Zip _____	
UPIN No. _____			Office Phone () _____			Office Fax () _____				
Physician Signature _____					Date _____					
Toll Free Fax: 1-800-289-8230										