

Diabetes Testing Supplies -Test Strips and Meters

Medicare Part B Coverage Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

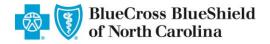
Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

D		Form May Delay Processing	
Pres Physician Name:	criber Information NPI #:	Patient Information Patient Name:	
Office Contact Person:		Patient ID #:	
Office Phone #:	Office Fax #:	Home Phone #:	
Address:		Sex: □ Female □ Male	
City:	State: Zip:	DOB:	
	Diagnosis a	nd Medication Information	
Product Requested:	<u> </u>	Diagnosis Code:	
Strength and Route of Administration:		Dosing Schedule:	
Quantity per 30 Days:			
	Please a	nswer questions below	
THIS		ARE PART B (MEDICAL) REQUEST ONLY	
ability to regain ma 2. Please indicate the r ☐ Accu-Chek	g for a decision under the stan ximum function in serious jeop requested brand of diabetes to FreeStyle specify):	esting supplies: ☐ ReliOn ☐ True Metrix	
A. If NO , has the i. If NO to 3. levels within	patient been treated with a dia A. , has the patient been treaten the past 90 days?	estational diabetes?	
A. If YES , please	specify the particular product	(such as Omnipod, Medtronic):	
5. Does the patient use A. If YES , please	e a continuous glucose monito specify the particular product	or? □ Yes (such as Dexcom, Freestyle Libre):	□ No
A. If NO , what lim		abetes testing supplies?	□ No
	PLEASE (CONTINUE TO NEXT PAGE	



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7. Has the patient tried Lifescan (OneTouch) brand diabetes testing supplies?		□ No
8. Is the quantity requested <i>greater</i> than the set quantity limit of #204 test strips per 30 days? A. If YES , please provide a clinical rationale in support of the quantity requested, including how often the patient is testing their blood sugar (may submit medical records to support this request):	□ Yes - -	□ No
I certify that I have appropriate authority to request a coverage decision for the medication indicated on this I further certify that the patient's medical records accurately reflect the information provided. I understand to NC may request medical records for this patient at any time in order to verify this information.	hat Blue	
Physician Signature: Date:		