

# Certificate of Medical Necessity



**Check if applicable:**

- FEP Field Evaluation Program
- DCP DexCom Continuation Program

This form functions as a Prescription and Certificate of Medical Necessity for the Seven™ System and all associated diabetes management supplies for a lifetime need.

PATIENT NAME (FIRST/ LAST) \_\_\_\_\_

PATIENT DOB \_\_\_\_\_

ADDRESS (NO P.O. BOX) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

DATE DIAGNOSED \_\_\_\_\_ TYPE 1 \_\_\_\_\_ TYPE 2 \_\_\_\_\_

GESTATIONAL \_\_\_\_\_ ICD-9 CODE \_\_\_\_\_

CLINICAL INDICATIONS FOR THERAPY
Check all that apply:
<input type="checkbox"/> Wide fluctuations in blood glucose values
<input type="checkbox"/> AM hyperglycemia (dawn phenomenon)
<input type="checkbox"/> Extreme insulin sensitivity
<input type="checkbox"/> Hypoglycemia unawareness
<input type="checkbox"/> Nocturnal hypoglycemia
<input type="checkbox"/> Diabetic ketoacidosis
<input type="checkbox"/> Elevated values
<input type="checkbox"/> Uncontrolled glycemic control post-renal
<input type="checkbox"/> Nephropathy
<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Retinopathy
<input type="checkbox"/> Other conditions:

PRESCRIPTION INCLUDES
Check all that apply:
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
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## PHYSICIAN INFORMATION

CLINIC / PRACTICE NAME \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

UPIN # \_\_\_\_\_

PRESCRIBING PHYSICIAN NAME (PRINT) \_\_\_\_\_

NPI: (National Provider Identifier: Required) \_\_\_\_\_

OFFICE CONTACT NAME \_\_\_\_\_

OFFICE PHONE \_\_\_\_\_

## PHYSICIAN SIGNATURE

<b>DexCom Only</b>
Rep name / # _____
Starter kit SN _____

## DATE

<b>Customer Service Only</b>
Customer # _____
Location # _____ Rev _____ Lot # _____

Fax Toll Free to: 1-877-633-9266 Customer Service: 1-877-DEXCOM4 (339-2664)