CONFIDENTIAL HEALTH INFORMATION

This form will be used by Dexcom to help identify your specific clinical indications that are in line with an insurance company's medical criteria for covering the Dexcom CGM system.

TELL US ABOUT YOURSELF

Your Name:	
Date of Birth:	
Physician Name:	
Date Diagnosed With Diabetes:	○ Type 1 ○ Type 2

HOW YOU MANAGE YOUR DIABETES

Current Number of BG Tests Per Day:		
Insulin Therapy (check one): ○ Insulin Pump ○ Injections ○ Other		
If injections, number of injections per day: If insulin pump, date started:		
Last 2 HbA1c Lab Results	HbA1c: Date:	HbA1c: Date:

TELL US ABOUT YOUR DIABETES

Do you have consistently higher glucose values in the morning than when you go to bed?	○ Yes ○ No
Do you consider yourself extremely sensitive to insulin?	○ Yes ○ No
Do you have nighttime hypoglycemia (<70mg/dL)?	○ Yes ○ No
Do you have recurring hypoglycemia (<70mg/dL) throughout the day?	○ Yes ○ No
Do you have hypoglycemic unawareness?	○ Yes ○ No
Are you planning a pregnancy?	○ Yes ○ No

Please provide estimates of the following if applicable:

Number of times you have been below 50mg/dL within the past 3 months _____

Number of paramedic visits within the last year _____

Number of low blood glucose events requiring assistance from others in the last year _____

Highest BG within the last month _____ Lowest BG level within the last month _____

Number of diabetes-related hospital visits within the last year _____
(Please explain below)

_____

_____

_____

Diabetes-related complications (please list if applicable):

1. _____
2. _____
3. _____

Anything else you would like us to know to help support your need for a Dexcom CGM system?

_____

_____

Please fax completed form and front/back of insurance card to Dexcom at: **1.877.633.9266** or mail to: Dexcom, 6340 Sequence Drive, San Diego, CA 92121 **ATTN: Customer Operations**

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