BECN 15279009686

BINSON'S
Medical Equipment & Supplies
Since 1953
586-755-2300

**FAX BACK TO**:
Michigan Fax: 1-586-755-2322
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reset form

# Diabetes Supplies – Written Order

Patient Name _____ DOB _____ Account Number _____

Order Date _____ Length of Need, 99 (lifetime) or _____ months

Diagnosis _____

Is the patient treated with insulin injections and/or an insulin pump? ☐ Yes ☐ No

## TESTING FREQUENCY (Based on a three-month order)

- ☐ 1 Time Per Day (100 Strips & 100 Lancets)
- ☐ 2 Time Per Day (200 Strips & 200 Lancets)
- ☐ 3 Time Per Day (300 Strips & 300 Lancets)
- ☐ 4 Time Per Day (400 Strips & 400 Lancets)
- ☐ 5 Time Per Day (500 Strips & 500 Lancets)
- ☐ Other: _____

## BLOOD GLUCOSE MONITOR

- ☐ Glucose Monitor
- ☐ Glucose Monitor for Visually Impaired.

  Visual Acuity: _____ Necessary for the monitor for the visually impaired.

## ACCESSORIES

- ☐ Test Strips
- ☐ Lancets
- ☐ Lancing Device
- ☐ Batteries (as requested)
- ☐ Control Solution

****Required For *MICHIGAN* Medicaid Patients Only ****
**Reason for Medical Necessity (other than diagnosis):** _____

**Prescribers Printed Name & Credentials** _____ **NPI** _____

**Phone** _____ **Fax** _____

**Signature** _____ **Date** _____

Diabetes Written Order 2/29/24



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