Please forward all correspondence to:
CMN (Certificate of Medical Necessity)
ABCO Medical Supply
Ph: (888) 899-8881 • Fax: (888) 606-4866 • ABCOMedicalSupply.com

Patient Name: ____________________ Insurance ID#: ____________________

Address: ____
City *State* *Zip*

Patient Phone: ____________________ DOB: ______________ SSN #: ____________________

Patient Height: ______________ Patient Weight: ______________ *(Both are required for mobility devices)*

CGM PRODUCTS ORDER FORM

DIAGNOSIS: ❑ Type 1 Diabetes ❑ Type 2 Diabetes ICD 10: ____________ ____________

Is your patient currently on insulin? ❑ Yes ❑ No

CGM PRODUCTS:

❑ **Dexcom G6** supplies as follows:

- ❑ Receiver
- ❑ Transmitter (one every 90 days)
- ❑ Sensors (change every 10 days)

Refills/months: Sensors ____________

Transmitter ____________

❑ **Dexcom G7** supplies as follows:

- ❑ Receiver
- ❑ Sensors (change every 10 days)

Refills/months: Sensors ____________

❑ **Freestyle Libre 3** supplies as follows:

- ❑ Receiver
- ❑ Sensors (change every 14 days)

Refills/months: Sensors ____________

❑ **Freestyle Libre 2** supplies as follows:

- ❑ Receiver
- ❑ Sensors (change every 14 days)

Refills/months: Sensors ____________

Provider Information

Physician Name: ______________________________ NPI: ____________________

Phone: ______________________________ Fax: ____________________

Address: ____
City *State* *Zip*

Attending Physician Signature: ______________________________ Date: ____________
(Original signature ONLY—no stamps)

INSTRUCTIONS: Please fill out this form and fax demographics, office visit notes and form to ABCO Medical Supply at (888) 606-4866.