HealthCare
BARNSTABLE BROWN DIABETES CENTER
2195 Harrodsburg Road, Suite 125, Lexington, KY 40504 859-323-2232, option 3

Diabetes Prevention Program Certificate of Medical Necessity (Patient Order Form)

Referral from: Physician Name: _____ Fax #: _____

Patient Data: Name: _____

DOB: _____ Social Security #:_____

Address: _____

Primary Phone #:_____ Other Phone#:_____

Insurance Type_____ **(PLEASE INCLUDE COPY OF PATIENT'S INSURANCE CARD)**

☐ Please mark if patient has no insurance and is self-pay

RX: Please write current ICD-10 diagnoses here_____ or, select from the list below by marking the line with a "X":

Diagnosis

____ R73.09 Prediabetes (abnormal fasting glucose)
____ R73.02 Prediabetes (Impaired glucose tolerance)

Patients with special needs requiring individual instruction

Please mark all that apply:

☐Vision ☐Hearing ☐Physical ☐Cognitive Impairment
☐Language Limitations (Interpreter Needed-specify language needed) _____
☐Other: _____

DPP Eligibility Criteria: Must provide one of the Prediabetes Diagnostic Criteria:

FBG≥ 100mg/dL to ≤ 125mg/dL BG: _____ Date: _____

2-hour OGTT ≥ 140-199mg/dL 2 hr OGTT (75 grams) BG: _____

Date: _____

A1C (5.7% to 6.4%) A1C:_____ Date:_____

Please verify the following information:

☐ No history of Diabetes (Type 1 or Type 2)

Yes or No **≥ 18 years of age**

Yes or No **BMI ≥ 25kg or ≥ 23mg if Asian**

Yes or No **Patient is NOT pregnant**

Yes or No **History of Gestational Diabetes Mellitus**

SIGNATURE REQUIRED MD/DO/APRN/PA: _____ DATE: _____

PLEASE FAX COMPLETED FORM TO 859-257-0659