MI CLINICA HISPANA

P: 903-710-1400
F: 18007834511
3505 Summerhill Road Suite 5
Texarkana, Texas 75503

Diabetes Self-Management Education & Support/Training & Medical Nutrition Therapy Services ORDER FORM

MEDICARE COVERAGE: ***Diabetes self-management educationand support/training(DSMES/T) andmedicalnutritio are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes.***

DSMES/T: ***10 hours initial DSMES/T in 12-month period from the date of first session, plus 2 hours follow-up per year with written referral from the treating qualified provider (MD/DO, APRN, NP or PA) each year.***

MNT: ***3 hrs initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours avai change in medical condition, treatment and/or diagnosis with a written referral from any physician (MD/DO).***

Medicare coverage of DSMES/T and MNT requires the referring provider to maintain documentation of a diagnosis of diabetes based on the following:

- ☐ ***fasting blood glucose greater than or equal to 126 mg/dl on two different occasions***
- ☐ ***2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions***
- ☐ ***random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes***

****Other payors may have other coverage requirements(Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register)***

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____/_____/_____ Gender: ☐ Male ☐ Female ☐ Other: _____

Address _____ City _____ State _____ ZipCode _____

Home Phone _____ Cell Phone _____ Email address _____

Diagnosis

Pleasesendrecent labs that support diagnostic criteria for patient eligibility & outcomes monitoring

☐ ***Type 1*** ☐ ***Type2*** ☐ ***Gestational*** ☐ ***Diagnosis code*** _____

Diabetes Self-Management Education & Support /Training (DSMES/T)

Check type of training services and number of hours requested

- ☐ Initial DSMES/T 10 or _____ hours
- ☐ Follow-up DSMES/T 2 hours
- ☐ If more than one hour individual initial training requested, please check special needs that apply:
  - ☐ ***Vision***
  - ☐ ***Hearing***
  - ☐ ***Language***
  - ☐ ***Cognitive***
  - ☐ ***Physical***
  - ☐ ***No group sessions available within 2 months pandemic***
  - ☐ ***Other (specify)*** _____

☐ All content areas identified by DSMES Team on assessment
OR Specific Content areas (Check all that apply)

- ☐ ***Pathophysiology of diabetes and treatment options***
- ☐ ***Healthy coping***
- ☐ ***Healthy eating***
- ☐ ***Being active***
- ☐ ***Taking medication (including Insulin and/or Injection training)***
- ☐ ***Reducing risk (treating acute and chronic complications)***
- ☐ ***Problem solving (and behavior change strategies)***
- ☐ ***Preconception, pregnancy, gestational diabetes***
- ☐ ***Monitoring***

Medical Nutrition Therapy (MNT)

Check the type of MNT requested

- ☐ ***Initial MNT 3 hours***
- ☐ ***Annual follow-up MNT 2 hours***
- ☐ ***Additional MNT hours for change in:***
  - ☐ ***medical condition***
  - ☐ ***treatment***
  - ☐ ***diagnosis.***

Signature of qualified provider certifies that he or she is managing the beneficiary's diabetes care for DSMT referrrals.

Signature and NPI # _____ ***Date*** _____/_____/_____

Group/practice name, address and phone: _____