Finnegan HEALTH SERVICES
6805 W. 12th Street, Suite F
Little Rock, AR 72204
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

Diabetic Supplies Order Form

Fax to **501-663-6668**. We'll take care of the rest. Form also available at: **finneganhealth.com/forms**

1 REFERRER

Referrer Name: _____
Facility/City: _____
Phone #: _____
Email: _____

2 CLINIC

Physician's Name: _____
Clinic/City: _____
Phone #: _____
NPI #: _____

3 PATIENT INFORMATION

Name: _____
Date of Birth: _____ **Sex:** M *or* F
Phone #: _____
Email: _____
Address: _____
City/State/Zip: _____
Emergency Contact: _____
Contact #: _____ *Relationship:* _____

Medicaid #: _____
Medicare #: _____
Does patient get home health care *(Medicare only)*? Y *or* N
Insurance Company: _____
Phone #: _____
Policy #: _____ **Group #:** _____

Does patient need automatic shipment? Y *or* N
How often? Monthly Every other month Quarterly

5 METER & SUPPLIES

Does the patient need a new meter? ☐ Yes ☐ No

If yes, choose one?
☐ Accucheck Nano
☐ Contour EZ
☐ Embrace
Other: _____

If no, what is current meter?
Brand: _____
Model: _____

Additional Testing Supplies:
Blood Testing Strips:
☐ 50 ☐ 100 ☐ 150 ☐ 200 ☐ 250
Lancets:
☐ 100 ☐ 200 ☐ 300

6 MEDICAL INFORMATION

- ICD-10-CM Diagnosis Code: _____
- No. of times a day patient checks blood sugar: _____
- Is the patient treated by: ☐ Insulin shots ☐ Oral meds
- Refills Are: ☐ 6*(Medicaid)* or ☐ *12(Medicare)*
  unless otherwise noted
- Is patient pregnant?: ☐ Yes ☐ No | Due date: _____

M.D.,APN, PA signature _____

Date: _____