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

Diabetec 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

- ☐ Verio
- ☐ Verio Flex
- ☐ Contour Next
- ☐ True Metrix
- ☐ Embrace

Other: ____________

Choose One:

Blood Testing Strips:

☐ 50 ☐ 100 ☐ 150 ☐ 200 ☐ 250 ☐ 300

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. signature ____________________

Date: ____________________