



Assignment of Benefits and Authorization for Release of Information

DexCom, Inc. recognizes that medical information is confidential and will maintain the privacy of your medical information. Information will only be used and disclosed in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, many insurance companies require that medical information be submitted with claims to determine medical necessity. In order to authorize DexCom to obtain medical information from your healthcare team, please complete, sign and date the statement below.

I, _____, do hereby authorize DexCom to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to DexCom for my continuous glucose monitoring products. I also authorize DexCom to submit referrals to DexCom's contracted distributors if necessary to obtain reimbursement. I understand I am responsible for any deductible, co-payment, and other amounts not covered by my insurance company/companies. DexCom will make every reasonable effort to collect payment from my insurance company. In the event the insurance company refuses to pay DexCom, I will assume full responsibility for the payment. I understand that if my insurance company does not accept assignment of benefits, all correspondence and payments for service may be sent directly to me. I agree when such payments are received by me, I will make payment on my bill with a credit card, personal check, or by endorsing the insurance check "Pay to the Order of DexCom" within five days. I agree to notify DexCom immediately of any changes to my insurance coverage or if I change my insurance company. I consent to the release of all information, including medical records to or from my physician or representative of my physician and to or from the insurance company or DexCom contracted distributors, for the purposes of healthcare management and/or for processing of medical claims.

Patient / Guardian Signature

Date

Print Patient Name

Address

City / State / Zip

Phone Number

Please fax completed form with copy of front & back of insurance card to:

Patient Insurance Information



Please provide the following to begin the insurance claims filing process.
All information is personal and confidential.

PATIENT INFORMATION			
Patient Name:		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
Date of Birth:	E-mail Address:		
Address:			
City:	State:	Zip:	
Home Phone: ()	Work Phone: ()	Cell Phone: ()	

PRESCRIBING PHYSICIAN			
Physician Name:		Group Practice Name:	
Address:			
City:	State:	Zip:	
Phone: ()	Fax: ()		
Office Contact Name:	Office Contact Title:		
Date of Diagnosed:	Check One: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational		

PRIMARY INSURANCE INFORMATION			
Insurance Company Name:		Phone: ()	
Claims Mailing Address:			
City:	State:	Zip:	
Policy Number:	Group Number:		
Policy Holder Name:	Date of Birth:		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		Employer:	

SECONDARY INSURANCE INFORMATION			
Insurance Company Name:		Phone: ()	
Claims Mailing Address:			
City:	State:	Zip:	
Policy Number:	Group Number:		
Policy Holder Name:	Date of Birth:		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		Employer:	

While every attempt is made to provide up-to-date information, DexCom, Inc. does not ensure the accuracy of the information provided. Since health or medical insurance reimbursement is affected by many factors, DexCom, Inc. makes no representation or guarantee that a patient will be successful in obtaining insurance reimbursement or any other payment.

Please fax completed form (with copy of AOB and front & back of insurance card) to:
1-877-633-9266



DexCom Health Questionnaire

This form will be used by DexCom to help identify your specific clinical indications that are in line with many insurance company's medical criteria for covering the DexCom SEVEN PLUS® system.

Please complete this form and return to DexCom via fax at 877-633-9266.

Tell us about you:	
Your Name	
Date of Birth	
When were you diagnosed with Diabetes (year)	
Physician Name	
How do you manage your diabetes:	
Current Number of Blood Glucose Tests Per Day	
Type of Insulin Therapy (Choose One)	Insulin Pump Injections Other
Number of Insulin Injections Per Day (if applicable)	
Last 2 HbA1c Lab Results	HbA1c Result: Date: HbA1c Result: Date:
Tell us about your diabetes:	
Do you have consistently higher glucose values in the morning than when you go to bed?	Yes No
Do you consider yourself extremely sensitive to insulin?	Yes No
Do you have nighttime hypoglycemia (<70 mg/dl)?	Yes No
Do you have recurring hypoglycemia (<70 mg/dl) throughout the day?	Yes No
Number of times you have been below 50 mg/dl within the past 3 months (estimate)?	
Do you have hypoglycemic unawareness?	Yes No
Number of diabetes-related hospital visits within the last year (please explain)	
Number of paramedic visits within the last year	
Number of low blood glucose events requiring assistance from others in the last year	
Highest and lowest blood glucose levels within the last month	High: Low:
Diabetes related complications (please list):	1.) 2.) 3.)
Are you pregnant or planning a pregnancy?	Yes No
Anything else we should know to help support your need for a DexCom SEVEN	

Patient (or Guardian) Signature

Date



Letter of Medical Necessity and Prescription Order
LONG-TERM USE SEVEN® CONTINUOUS GLUCOSE MONITORING SYSTEM

This form functions as a Prescription and Letter of Medical Necessity for the Continuous Glucose Monitoring System and all associated diabetes supplies to be provided by DexCom or an authorized distributor.

Please complete and check all applicable areas:

Patient First Name: _____ Last Name: _____ DOB: _____
 Address: _____ Male Female
 City: _____ State: _____ Zip code: _____
 Home Phone #: _____ Work #: _____ Cell #: _____

ICD-9 Code: _____ **Prescription duration:** Lifetime need No substitutions
Date of Diagnosis: _____ **Prescription for HCPCS codes:** A9278, Receiver (Monitor), 1/365 days
 A9277, Transmitter, 1/365 days
 A9276, Sensors (1 unit=1 day), 90/90 days

Patient's existing conditions supporting medical necessity for long-term continuous glucose monitoring system:

- Completed comprehensive diabetes education. Date: _____
- Demonstrates compliance with medication, diet, and MD treatment.
- Tests with fingerstick blood glucose _____ times daily as documented by log book or meter download.
- MDI/Multiple daily insulin injections: _____ injections per day.
- Has an insulin pump. Start date of insulin pump therapy: _____
- Experiences hypoglycemia episodes (Less than 50 mg/dl).
- Severe hypoglycemic reactions requiring the assistance of others.
- Unscheduled urgent clinic and/or ER visits to treat significant hypoglycemic episodes.
- Receives care from an endocrinologist or a diabetes specialty clinic.

Clinical indications for long-term continuous glucose monitoring system:

- Wide fluctuations in blood glucose values from _____ to _____ mg/dl
- Hypoglycemia unawareness
- AM hyperglycemia (Dawn Phenomenon)
- Nocturnal hypoglycemia
- Diabetic ketoacidosis
- Neuropathy/nephropathy/retinopathy
- Pre-conception planning
- Fasting hyperglycemia > 150mg/dl
- Inadequate glycemic control despite appropriate adjustments in insulin therapy and compliance with frequent self-monitoring
- Recent A1C value _____ % Date of test: _____
- Other _____

Please attach documentation supporting the information checked (Log book, meter download, clinical notes, urgent care, emergency room documentation, etc.).

Continuous glucose monitoring system training:

Teaching will be completed by physician and staff Other trained personnel name: _____

Name of Prescribing Physician: (print) _____
 Specialty: _____ UPIN: _____
 Office Address: _____ NPI: _____
 City: _____ State: _____ Zip code: _____
 Office Phone #: _____ Fax #: _____ Office Contact: _____

Physician Attestation & Signature/Date:

I certify that I am the physician identified above & have reviewed all of the order information above. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify all the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of the products marked above. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician's Signature: _____ Date: _____

(Stamps are not acceptable, signature and date must be handwritten)

Fax Toll Free to: 1-877-633-9266 Customer Service: 1-877-DEXCOM4 (339-2664)