Convenience ▪ Affordability ▪ Choice™

Byram HEALTHCARE

Please complete and fax to: 1-888-457-1277

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Email Address: _____ Gender: ☐ Male ☐ Female

INSURANCE INFORMATION (please attach copies of the patients insurance card front and back)

Primary Insurance: _____ Primary Insurance ID: _____

Secondary Insurance: _____ Secondary Insurance ID: _____

PROVIDER INFORMATION

Provider First Name: _____ Provider Last Name: _____

Phone: _____ NPI: _____

Address: _____ City: _____ State: _____ ZIP: _____

PRODUCT

Tandem	MiniMed	Insulet (Pharmacy)	Sequel (Pharmacy)	Beta Bionics
☐ t:slim x2	☐ 780G	☐ Omnipod Dash	☐ Twiist Starter Kit	☐ iLet
☐ Mobi	☐ Flex	☐ Omnipod 5 Starter Kit	☐ Twiist Refill Kit/Infusion	
		☐ Omnipod 5 Reorder Kit		

- NY Medicaid Only | Indicate # of Refils _____
- Insulin Pump E0784 (1/365)
- All necessary Pump Supplies (Reservoirs, Infusion Sets, Omnipods); A4230, A4231, A4232, A4224, A4225; 90 day supply refillable for 1 year.
- Infusion set name and size: _____
- Changing every 3 days. If changing less than 3 days please note here: _____

PRODUCT

Abbott	Dexcom	Senseonics	MiniMed
☐ Libre 2 PLUS* ☐ Libre 3 PLUS	☐ G7 ☐ G7 15-Day	☐ Eversense 365	☐ Guardian 4 ☐ Simplera Sync ☐ Instinct

- Continuous Glucose Monitoring System (K0553, K0554, A4238, E2102, A4239, E2103, A9276, A9277, A9278) Sensor;
- 90 day supply refillable for one year. Change sensors per manufacturer FDA approved directions.
- Transmitter; (if applicable with system); 4/365 days. Use per manufacturer FDA approved directions.
- Reader/Receiver; 1/365 days. Use per manufacturer FDA approved.
- Other _____

Testing Supplies ☐

- Glucose Tests Per Day _____
- All necessary testing supplies (meter, lancing device, test strips, lancets, control solution, batteries) for a 90 day supply and refills for 1 year

DIAGNOSIS (ICD10):

_____

Provider Signature: _____ **Date:** _____

I certify that I am the physician/practitioner identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes and other supporting documentation will be provided to Byram Healthcare upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

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