VALLEY HEALTH

1 Harbour Way | Milton WV 25541
304.781.5044

Please fax completed referral form to (304.390.0003)

Valley Health Diabetes Education Program

See back for instructions on how to complete form.

A. PATIENT INFORMATION:

Gender: Male Female Other:_____

Patient's Last Name **First** **Middle** **Date of Birth**

Address **City** **State** **Zipcode**

Home Phone **Cell Phone** **Email Address**

Insurance **Insurance Identification Number**

** Please send insurance authorization (CPT code G0108) and a copy of patient's insurance card (front/back)*

B. DIABETES DIAGNOSIS:

DM Type:_____ ICD-10 Dx Code:_____

**Please send last progress note, medication list, and most recent labs including A1C for patient eligibility & outcomes*

C. DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT/TRAINING (DSMES/T):

Referral For:

Choose **(ONLY ONE)**

☐ Initial Comprehensive DSMES/T - 1O (all 9 content areas) or less hrs:_____

☐ DSMES/T: Follow-up - 2 hrs

Indicate any special training needs or accommodations needed for the patient:

(Check all that apply)

☐ Impaired mobility ☐ Impaired vision ☐ Impaired hearing ☐ Impaired dexterity

☐ Impaired mental status/cognition ☐ Language barrier ☐ Eating disorder ☐ Learning disability

☐ Other (please 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
☐ Other:_____

D. HEALTH CARE PROVIDER INFORMATION:

**Signature of qualified provider certifies that he or she is managing the beneficiary's diabetes care for DSMES/T referrals.*

Provider's Name (Printed): _____ Provider's NPI # :_____

Group/Practice Name:_____

Phone Number:_____ Fax Number:_____

Provider's Signature _____ Date _____ / _____ / _____

VALLEYHEALTH

Diabetes Education Program

Instructions on How to Complete the Referral Form

SECTION A: PATIENT INFORMATION

- Include the patient's full name, address, phone number(s) where the patient can be reached; email address (if applicable), and gender.
- **Attach** insurance authorization (CPT Code: G0108) with a copy of the patient's insurance card (front and back) with the referral.

SECTION B: DIABETES DIAGNOSIS

- Include the type of diabetes.
- Include the diagnosis code that corresponds with the patient's diabetes diagnosis.
- Medicare coverage of diabetes self-management education and support/training (DSMES/T) 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
- **Attach** last progress note, medication list, and most recent labs including A1c with referral.

SECTION C: DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT/ TRAINING

- **MEDICARE COVERAGE:** DSMES/T is a separate and complementary service to improve diabetes self-care.
- **DSMES/T:** 10 hours initial DSMES/T in 12-month period from the date of first session, plus 2 hours follow-up per calendar year with written referral from treating qualified provider (MD/DO, NP, or PA) each year.

SECTION D: HEALTH CARE PROVIDER INFORMATION

- Include the treating qualified health care provider's name, provider NPI #, group/ practice name, and telephone/fax number.