VALLEYHEALTH
1 Harbour Way | Milton WV 25541
304.781.5044

Please fax completed form to (304.390.0003)

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:

☐ **Type 1 DM** ☐ **Type 2 DM** ☐ **Gestational DM** **ICD - 10 DX Code:_____**

Please send last progress note,medication list, and most recent labs including A1c for patient eligibility & outcomes monitoring.

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

Referral For:

Choose **(ONLY ONE)**

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

☐ DSMT: Follow-up - 2 hrs

Indicate any barriers to learning or additional insulin training requiring 1:1 education:

(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 DSMT 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:

- **Select the type of Diabetes (Type 1, Type 2, Gestational Diabetes) and include the diagnosis code that corresponds with the patient's diabetes diagnosis. Please note that the patient has to have a diabetes diagnosis, not Prediabetes/Hyperglycemia, Hypoglycemia.**
- **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.**