

# Patient Questionnaire & Statement of Medical Necessity

Please provide the following information to begin the insurance benefit verification process. The following information may also be used to provide other services to you for marketing research purposes internal to Abbott Diabetes Care. This does not obligate you to obtain the FreeStyle Navigator Continuous Glucose Monitoring System.

## Authorization to Release Information:

I request and authorize my insurance companies and team of healthcare professionals working with the Abbott Diabetes Care (ADC) Resource Center (the "Resource Center") to release to Abbott Diabetes Care and Customer Care Center, or third parties contracted by Abbott and/or the Resource Center (collectively, "ADC") any information regarding my health, treatment, and coverage that pertains to payment and training for the FreeStyle Navigator® Continuous Glucose Monitoring System.

The "Resource Center" includes all reimbursement services, Customer Care services, and support. I understand that I need to give my authorization to take part in the Resource Center. However, if I do not provide this authorization, my decision will not affect my ability to obtain treatment from my healthcare providers or decisions about payment, enrollment, or eligibility for benefits made by my insurance companies. I know I may cancel this authorization at any time by writing to the Abbott Diabetes Care Resource Center, P.O. Box 1087, San Bruno, CA 94066. If I cancel this Authorization, I can no longer participate in services provided by the Resource Center.

In addition to using my information for the Resource Center, I authorize ADC to use and disclose my information to: (i) assist with my healthcare reimbursement and coverage for the FreeStyle Navigator, (ii) assist with the assessment of my eligibility for the FreeStyle Navigator system, (iii) send me information related to FreeStyle Navigator system and related products, services, and assistance\*; (iv) conduct internal review and analysis; (v) maintain the high quality of the Resource Center's services; and (vi) comply with the law.

I agree that ADC does not have any liability in providing any service through the Resource Center to me. I understand that the Resource Center may be changed or discontinued at any time without notice to me.

\*Please check this box if you do not wish to receive product and service information.

By signing below, I certify that I am currently 18 years of age or older.

Print Patient Name:	Patient / Representative Signature:
Phone #:	Date:

**Notice to Healthcare Providers and Insurers:** This form of authorization may not comply with all applicable federal and state laws governing disclosure of the applicant's information to ADC and its contracted third parties. ADC urges all entities disclosing information about the patient to consult with legal counsel prior to relying on this form.

**Patient Questionnaire & Statement of Medical Necessity**

**Patient Information** (*Patient, please complete this section*)

Last Name:	First Name:	Middle Initial:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth:
Home Phone #:	Cell Phone #:	Email:		
Street Address:	City:	State:	Zip:	
Alternate Contact:	Contact #:	Relationship:		
Primary Insurance Name:	Primary Insurance Phone #:			
Card Holder's Name:	Relationship To Patient:	Card Holder's Employer:		
Policy ID:	Group ID:	<input type="checkbox"/> Contact Me for Additional Insurance Information		

**Patient Medical Information: Please check all that apply** (*Prescriber, please complete this section*)

ICD-9 Code:	Date of Diagnosis:	<input type="checkbox"/> Patient Completed a Comprehensive Diabetes Education	
<input type="checkbox"/> Patient is on a program of multiple daily injections of insulin (i.e., 2 or more injections per day) with self-adjustments of insulin dose. Number of injections per day _____			
Number of BG Tests per Day: _____	<input type="checkbox"/> Patient is on Insulin Pump	<input type="checkbox"/> Patient experiences wide fluctuations in blood glucose before meal time	
<input type="checkbox"/> Pre-pregnancy Patient with <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2 Diabetes		<input type="checkbox"/> Patient has been hospitalized due to hypoglycemia unawareness	
Number of hospitalizations/emergency room visits due to complications from diabetes over lifetime: _____			
<input type="checkbox"/> Uncontrolled post-renal glycemc control <input type="checkbox"/> Fasting hyperglycemia (> 150 mg/dL) <input type="checkbox"/> Hypoglycemia Nocturnal <input type="checkbox"/> Severe hypoglycemic events (< 50 mg/dL) <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypoglycemia Unawareness	<input type="checkbox"/> Elevated Values <input type="checkbox"/> Pregnancy/Gestational Diabetes <input type="checkbox"/> Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Dawn Phenomenon <input type="checkbox"/> Diabetic Ketoacidosis	<input type="checkbox"/> Rebound/Fluctuating Glucose <input type="checkbox"/> Retinopathy <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Insulin Sensitivity <input type="checkbox"/> Depression <input type="checkbox"/> Inadequate glycemic control despite appropriate adjustments in insulin therapy & compliance with frequent self-monitoring	
Date of Last A1C:	Result of Last A1C:	Maximum A1C Over Past 36 Months:	Minimum A1C Over Past 36 Months:

Justification for Patient's Medical Need for FreeStyle Navigator® Continuous Glucose Monitoring System:

**Prescriber Information**

Prescriber Name:	Office Contact Name:		
Tax ID:	NPI:	Site Name:	Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:	City:	State:	Zip:
Phone #:	Fax #:	Physician's Specialty:	

**FreeStyle Navigator System Prescription Information**

<b>Product Training:</b> <i>At the Physician's discretion, FreeStyle Navigator training will be provided by a Physician/Educator or Abbott Diabetes Care (ADC).</i>	<b>Items/Accessories Ordered:</b> Sensors; invasive: A9276 (90/90 days) Transmitter: A9277 (1/365 days) Receiver (Monitor): A9278 (1/365 days) Other usage:	<b>Frequency of Sensor Site Change:</b> <input type="checkbox"/> Every 3 Days <input type="checkbox"/> Every 5 Days
		<b>Number of Sensor Kit Refills:</b> <input type="checkbox"/> 30 Day Supply <input type="checkbox"/> 90 Day Supply
<b>Patient Training (required):</b> <input type="checkbox"/> Physician/Diabetes Educator <input type="checkbox"/> ADC Provided Trainer	<input type="checkbox"/> Lifetime Need	<b>FreeStyle® Test Strips - Quantity:</b> ____ Strips / Day <b>Number of FreeStyle® Test Strip Refills:</b> <input type="checkbox"/> 30 Day Supply <input type="checkbox"/> 90 Day Supply
<b>Physician's attestation:</b> I certify that the use of this treatment is medically necessary, that I am the physician identified on this form, and that I will be supervising the patient's treatment. I have reviewed the Written Confirmation of Verbal Order. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed. I will also ensure that the patient and/or caregiver is adequately trained in its use.		Date of Therapy:
Prescriber's Signature:		Date:

