



MYDIABETESTUTOR REFERRAL FORM

FAX 844.306.5999

Thank you for the referral to My Diabetes Tutor. Please fax this completed and **SIGNED form** to 844-306-5999, **along with a copy of insurance cards, demographics, recent A1C, and other supporting labs and notes necessary for services.**

PATIENT INFORMATION

Full Name		Date of Birth	Gender	Other		
			Male Female Unknown			
Phone Number	Patient Email Address		Primary Language			
Diabetes Type					ICD10 code	
Type 1 Type 2 Prediabetes Gestational Pre-existing Diabetes in Pregnancy						
MNT Diagnosis					ICD10 code	
Reason for 1:1 visits: <input checked="" type="checkbox"/> No groups in 2 mo. or virtual program distance language mobility cognition vision hearing						
A1C (within 3 months of referral) %	Date	LAB Preferred				
PHARMACY preferred				Pharmacy Phone		
Provider Name		Phone		Fax		
Provider Practice Name			Next Provider Visit			
INSURANCE Name						
REFERRING Entity						Other
Adventist Alignment Aria Dignity Imperial Kaweah Sante Tricare United						

OPTION 1

DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT (DSMES)

Check education / training needed:

Initial DSMES 10 (or hours) - New diagnosis, or no prior diabetes education. Includes nine standard topic areas, tailored to needs, with provider updates.

Annual DSMES (2 hours) - Health maintenance, complication prevention, new factors influencing self-care.

Additional DSMES for change in medical condition/treatment.

Continuous Glucose Monitoring - Device Training

Insulin Related, plus Initial DSMES 10

Provide insulin dose education per referring provider's orders. Adjust either injectable long-acting (basal) or short-acting (bolus) insulin per visit—but not both:

Adjust 1 unit daily until FBS 80-130 mg/dL (or mg/dL); May adjust bolus or I:C ratios up to 20%.

Insulin Pump Start Insulin Pump Ongoing Training CDCES CPT may adjust Target Glucose, Correct Above, Insulin Duration, ISF, I:C ratio, and basal rate.

OPTION 2

MEDICAL NUTRITION THERAPY (MNT)

Approve the following number of hours as authorized by insurance:

Initial MNT 3 hours Annual follow-up MNT 2 hours Additional MNT hours for change in medical condition / diagnosis

OPTION 3

REMOTE PATIENT MONITORING (RPM), CHRONIC CARE MANAGEMENT (CCM), ENDOCRINOLOGY PROVIDER CONSULT

Check service type needed:

RPM: I verify patient provides consent to verify insurance and I approve number of hours authorized.

CCM: I verify patient provides consent to verify insurance and I approve number of hours authorized.

Endocrinology provider consult.

I affirm managing this patient's medical condition and that the above referral is a necessary part of their management.

Provider NPI#

Provider Signature REQUIRED for Services

Date