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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