BlueCross BlueShield of North Carolina

Diabetes Testing Supplies
Medicare Part B Coverage Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Decision
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information
Physician Name:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Drug Requested:	Diagnosis Code:
Strength and Route of Administration:	Dosing Schedule:
Quantity per 30 Days:	

Please answer questions below

THIS FORM IS FOR A MEDICARE PART B (MEDICAL) REQUEST ONLY

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

2. Please indicate the requested brand of diabetes testing supply:
   ☐ Accu-Chek ☐ FreeStyle ☐ ReliOn ☐ True Metrix
   ☐ Other (please specify): _____

3. Does the patient have diabetes, prediabetes, or gestational diabetes?..... ☐ Yes ☐ No
   A. **If NO**, has the patient been treated with a diabetes medication within the past 90 days?..... ☐ Yes ☐ No
      i. **If NO to 3.A.**, has the patient been treated with a concomitant drug that may affect blood sugar levels within the past 90 days?..... ☐ Yes ☐ No

4. Does the patient use an insulin pump?..... ☐ Yes ☐ No
   A. **If YES**, please specify the particular product (such as Omnipod, Medtronic): _____
   _____

5. Does the patient use a continuous glucose monitor?..... ☐ Yes ☐ No
   A. **If YES**, please specify the particular product (such as Dexcom, Freestyle Libre): _____
   _____

6. Has the patient tried Ascensia (Contour) brand diabetes testing supplies?..... ☐ Yes ☐ No
   A. **If NO,** what limitations does this patient have precluding the use of this covered brand (include any additional clinical rationale for requesting coverage)?:
   _____
   _____

PLEASE CONTINUE TO NEXT PAGE

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7. Has the patient tried Lifescan (OneTouch) brand diabetes testing supplies?..... ☐ Yes ☐ No
   A. **If NO,** what limitations does this patient have precluding the use of this covered brand (include any additional clinical rationale for requesting coverage)?:
   _____
   _____

8. Is the quantity requested *greater* than the set quantity limit of #204 test strips per 30 days?..... ☐ Yes ☐ No
   A. **If YES**, please provide a clinical rationale in support of the quantity requested, including how often the patient is testing their blood sugar (may submit medical records to support this request):
   _____
   _____

I certify that I have appropriate authority to request a coverage decision for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/05/2022