CENTRAL NEW YORK DIABETES EDUCATION PROGRAM

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Outpatient Diabetes Services Order Form (DSMT and MNT Services)

Patient's Last Name | First Name | Middle

Date of Birth ____/____/____ Insurance Provider____________________ Gender____Male ____ Female

Address | City | State | Zip Code

Home Phone | Work Phone | Other Contact Phone

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually

**Check type of training services and number of hours requested:*

- ☐ Initial group DSMT: ☐ 10 hours or ____ no. hrs. requested
- ☐ Follow-up DSMT: ☐ 2 hours or ____ no. hrs. requested
- ☐ Additional insulin training: ____ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

Check all special needs that apply:

☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment

☐ Language Limitations ☐ Other __________

* DIAGNOSIS

ICD 10 Diabetes Mellitus Diagnosis Codes

- ☐ E11.9 Type 2 diabetes without complications
- ☐ E10.8 Type 1 diabetes with complications
- ☐ E10.9 Type 1 diabetes without complications
- ☐ E11.65 Type 2 diabetes with hyperglycemia
- ☐ E11.649 Type 2 diabetes with hypoglycemia (no coma)
- ☐ E11.21 Type 2 diabetes with nephropathy
- ☐ E11.22 Type 2 diabetes with chronic kidney disease
- ☐ E11.319 Type 2 diabetes with retinopathy(unspecified)
- ☐ E11.42 Type 2 diabetes with polyneuropathy (unspecified)
- ☐ ADD THIS ON TO ONE OF THE ABOVE E CODES AS NEEDED - Z79.4 diabetes with current insulin use

Gestational Diabetes

024.91 Unspecified Diabetes Mellitus in pregnancy

- ☐ **024.911 First trimester: # weeks gestation___**
- ☐ **024.912 Second trimester: #weeks gestation___**
- ☐ **024.913 Third trimester: #weeks gestation___**

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

** Check the type of MNT and/or number of additional hours requested:*

- ☐ Initial MNT ☐ Annual follow-up MNT
- ☐ Additional MNT services in the same calendar year, per RD recommendations ____ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

Specify type, dose and frequency

Oral:

Insulin:

Patient now uses: ☐ Pen ☐Syringe and vial ☐Pump

PATIENT BEHAVIOR GOALS/PLAN OF CARE

FBS: DATE:

HBA1C: DATE:

1-8650-7-284 Revised 10/2015

Date__________ Time__________*Signature and UPIN#__________

Group/practice name, address and phone: __________