Central Ohio Diabetes Association ◆ 1100 Dennison Avenue ◆ Columbus, Ohio 43201
614-884-4400/ fax 614-884-4484 www.diabetesohio.org

Physician Referral Form

***This form is required to receive education at the Central Ohio Diabetes Association including Medicare Part B Beneficiaries and must include a diagnosis code & physician signature to insure proper education, billing and reimbursement. Incomplete forms may result in scheduling delays.*

Date:____________________

Patient Name: ____**DOB:**____________________________

Address: _____________________________________**City:**____________________**Zip:** ______________

Patient Phone: (____) ____________________________**Phone Type:** ☐ **Home** ☐ **Cell** ☐**Work**

Insurance Carrier: ______________________________________**Member ID:** ____________________

Group #____________________ **Preauthorization # (if applicable)** _______________________________

Referred For:

- ☐ **DSMES – Diabetes Self-Management Education and Support Class Series**
- ☐ **Individual Counseling Session (due to schedule conflict or special needs):**
  - ☐ *MNT (Medical Nutrition Therapy)* ☐ *Medical Education (i.e. insulin training, medical counseling)*
- ☐ **Gestational Nutrition Counseling and/or Meter Training**
- ☐ **Meter and Strips Program** (*Patients with no insurance coverage or insurance does not cover a meter and/or strips.*)
- ☐ **Inch By Inch Lifestyle Management Program Series**
- ☐ **Blood Glucose Meter Training**
- ☐ **Other (please specify)** ____

***ICD Diagnosis Code(s):** ____
Examples: E11.8 Type II unspecified complications, E11.9 Type II without complications, Medical Nutrition Therapy Z71.3

Most recent A1c Results**______ **Date of test** __________ ☐ **Labs enclosed** ☐ **No current labs

***Practice Name:** ____

***Address:** ____

***Phone:** _________________________________**Fax:** ____

***PCP/Referring Physician** ***(Please Print)*:**____

***PCP/Referring Physician Signature:** ____________________________________**Date:**_____________

NPI#:______________________________ **Medicare #:**______________________________

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