



NEW PATIENT INFORMATION FORM

PO BOX 20008, Fort Pierce, FL 34979 • 1-866-DIABETES (1-866-342-2383)

Territory: _____

Referral Source: _____

PATIENT SECTION

PLEASE FAX COPY TO: 1-888-268-6406

Patient Name: _____ SSN: _____ DOB: _____

Home Phone: (____) _____ Alternate Phone: (____) _____ Email: _____

Shipping Address: _____ City, State, Zip: _____

Emergency Contact Name: _____ Emergency Contact Phone: (____) _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

Subscriber: _____ DOB: _____ Subscriber: _____ DOB: _____

ID #: _____ Group #: _____ ID #: _____ Group #: _____

Employer: _____ Employer: _____

This section must be completed by the patient or authorized caregiver in order for Liberty to process the patient's first order. If the section is not completed, a Liberty representative will contact the patient to obtain order information.

1 Strips _____; Meter _____ is the brand of product I am currently using or that my Doctor would prefer.

I have not had a glucose meter paid for by Medicare in the preceding five years, and if authorized by my physician below, authorize Liberty to send me a new meter for the brand of product indicated above. I authorize Liberty to send me all eligible supplies as prescribed by my physician below. I understand that I must confirm all additional orders with Liberty before my supplies can be shipped to me.

PATIENT AGREEMENT

I authorize Liberty to contact me by phone to discuss products and services that may be available to me. I authorize Liberty Medical Supply and/or any of their corporate affiliates (collectively "Liberty") to 1) bill Medicare, Medicare Supplemental, or other insurer(s) on my behalf, 2) release my medical information to these insurer(s) and their agents and assigns, and 3) obtain medical or other information, necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided. I understand that I may owe applicable deductibles and/or copays.

PATIENT SIGNATURE → [] SIGNATURE DATE → []

AUTHORIZED REPRESENTATIVE ATTESTATION

By signing below, I certify that if the patient has not executed the patient agreement above, that (i) I have spoken to the patient and discussed the products and services Liberty offers and (ii) that the patient has authorized me, as his/her representative to authorize Liberty to contact the patient by phone to discuss Liberty's products and services and (iii) as the patient's authorized representative, I authorize Liberty to contact the patient by phone.

Print Name _____ Relationship to Patient _____

AUTHORIZED REPRESENTATIVE SIGNATURE → [] SIGNATURE DATE → []

PHYSICIAN SECTION

1 Patient is attempting to control his/her diabetes with insulin injections Yes No

2 INJECTING FREQUENCY – (Injections per Day) NONE 1x 2x 3x 4x Other _____

3 DIAGNOSIS CODE – (ICD-9) 250.01 (IDDM) 250.00 648.80 Gestational Other _____

4 TESTING FREQUENCY – (Tests per Day) 1x 2x 3x 4x Other _____

5 I prescribe the following Diabetes Supplies and have crossed out the items I am not prescribing.

test strips lancets control solution lancet device battery glucose monitor

**If you would like to order insulin, insulin pens and/or syringes for your patient, a separate RX is needed.*

By my signature below, I confirm that the patient has diabetes and is/was being treated by me. All the information contained on this Doctor Order Form accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. For Medicare/Insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes. I certify, if I am a non-physician healthcare provider, that I have all necessary licensure and authorization under applicable state and federal law to treat this patient for his or her condition and to prescribe the above equipment and/or supplies.

I further certify, if the patient has not executed the Patient Agreement above, that (i) I have spoken with the patient and discussed the products and services that Liberty offers, (ii) the patient has authorized me, as his/her agent and representative, to authorize Liberty to contact the patient by phone to discuss products and services that Liberty offers and which may be available to such patient, and (iii) as the patient's authorized agent and representative, I hereby authorize Liberty to contact the patient by phone for such purposes. (cross out if not applicable)

Phys Name (printed): _____ NPI #: _____ Phone: _____

Phys Address: _____ Fax: _____

PHYSICIAN/ PRESCRIBER SIGNATURE → [] SIGNATURE DATE → []