Continuous Glucose Monitoring System

Prior Authorization Form

Quality and Utilization Improvement Dept. **Fax: (952) 853-8714** **Phone: 1 (888) 467-0774**

To be completed by a Health Practitioner (MD, NP, PA etc), not Vendor or Member.
Please print the answer to all of the following questions. This information is required in order to determine whether coverage criteria are met.

Member Name:	**Date of Birth:** ___/___/_____	**Member #:**
Form Completed by and date:	**Phone:** ( ) ____-_____	**Fax :** ( ) ____-_____

Treating MD:	**NPI #:**
MD Phone:	**MD Fax:**
Is ordering MD an Endocrinologist? _____ *(Note – this is a requirement for coverage.)*	

Diagnosis:_____**ICD9 or 10:**_____

Check the following that apply:

____History of Nocturnal Hypoglycemia
____Hypoglycemia unawareness
____Patient routinely has problems with hypoglycemia and hyperglycemia refractory to multiple adjustments in self-monitoring of blood glucose and insulin administration
____Patient has unexplained, large fluctuations in pre-prandial glucose levels

Attach any additional clinical information from member's medical record.

Physician or Treating Practitioner Signature:	**Date:**

CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.