TELCARE™
MEDICAL SUPPLY

150 Baker Avenue Ext, Ste 300
Concord, MA 01742
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Fax: 978-832-1071
www.telcare.com

PATIENT INFORMATION FORM FOR HOME GLUCOSE MONITOR & SUPPLIES

Please review this Detailed Written Order for accuracy, make all appropriate corrections, sign, date, enter NPI, then FAX to (978) 832-1071. THANK YOU.

PATIENT INFORMATION		PHYSICIAN INFORMATION	
NAME	First_____ Last_____ MI____	**NAME**	_____
ADDRESS	Street_____	**ADDRESS**	_____
			_____
	City_____ State_____ Zip_____		
TEL	_____	**TEL**	_____
DOB	(MM/DD/YY)_____	**FAX**	_____
GENDER	Male ☐ Female ☐	**NPI #**	_____
PRIMARY INSURANCE ID	_____	**DEA #**	_____

The above patient being referred for the Telcare BGM has _____ health insurance. They have been referred by a licensed healthcare professional representing _____ to use this device as a part of a diabetes management program. Please reach out to the patient's insurance provider, and confirm the co-pay for the Telcare BGM with the patient.

Care Manager Signature _____ **Date** _____