



Clinical Information for Insulin Pump

PART A: Patient/Provider Information – Please Print		
Patient Name (Last, First, MI)	Sponsor SSN	Date of Birth (mm/dd/yyyy)
Requesting Provider	Provider Fax #	

PART B: Clinical Information – Please check appropriate boxes and make comments as indicated – Please Print

Diagnosis: Diabetes Type: _____ Duration: _____
 Number of insulin injections per day: _____
 Number of units of insulin per day: _____
 Number of blood glucose tests per day: _____
 Fluctuation of blood glucose values: Range from _____ (low) mg/dl - to - _____ (high) mg/dl
 Most recent HbA1c: _____ Date: _____ (mm/dd/yyyy)

Current Diabetic Complications (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Dawn phenomenon | <input type="checkbox"/> Neuropathy – peripheral | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Neuropathy – autonomic | <input type="checkbox"/> Preconception |
| <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Retinopathy – non-proliferative | <input type="checkbox"/> Post renal transplant |
| <input type="checkbox"/> Nocturnal hypoglycemia | <input type="checkbox"/> Retinopathy – proliferative | <input type="checkbox"/> Gastroparesis |
| <input type="checkbox"/> Hypoglycemic unawareness | <input type="checkbox"/> Ketoacidosis | <input type="checkbox"/> Nephropathy |

Self-Management Practices (please check all that apply):

- Patient is self-monitoring blood glucose levels on a regular basis. (Submit blood glucose logs for the past 60 days with this form.)
- Patient has shown compliance on a multiple injection regimen while suffering suboptimal results.
- Patient has had emergency department visit(s) and/or hospitalization(s) for complications of diabetes. (Submit clinical documentation of the visit(s).)

Please fax this completed form with supporting clinical documentation and/or other relevant data to:

TriWest Healthcare Alliance – Fax: 866-269-5892

TRICARE Prime Remote, TRICARE Reserve Select – Fax: 866-312-5831

This data will be used in making a final determination.

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services.
 Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.”
 Violations of this may be punishable by fines, imprisonment, or both.