



Diabetes Self-Management Education & Support/Training (DSMES/T) and Medical Nutrition Therapy Services (MNT)

Cullman Diabetes Center

2110 AL Hwy 157 Cullman, AL 35058 Ph: 256-737-8038 F: 256-737-8006

MEDICARE COVERAGE:

Diabetes Self-Management Education & Support/Training (DSMES/T) and Medical Nutrition Therapy (MNT)

are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes.

DSMES/T : 10 hours initial DSMES/T in 12-month period from the date of first session with written referral from the treating qualified provider, plus **2 hours follow-up per subsequent calendar year.**

MNT : 3 hours initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis with a written referral from the treating physician only.

PATIENT INFORMATION **OKAY TO SKIP IF DEMOGRAPHIC FORM INCLUDED

Last Name _____ First Name _____ Middle _____
Date of Birth: ____ / ____ / ____ Gender: Male Female Phone: _____

Address _____ City _____ State _____ Zip Code _____

INSURANCE **OKAY TO SKIP IF DEMOGRAPHIC FORM INCLUDED

Primary: _____ ID#: _____ Group#: _____

Secondary: _____ ID#: _____ Group#: _____

Policy Holder: Same as above OR Name: _____ DOB: _____

DIABETES DIAGNOSIS

Type 1 Type 2 Gestational Diagnosis Code: _____

DSMES ORDERS:

If # of hours are not specified, DSMES team will default to # of hours allowed per benefit.

Initial DSMES _____ hours Follow-up DSMES _____ hours

DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT /TRAINING (DSMES/T)

Check type of training services and number of hours requested

ALL content as related to diabetes care plan and agreed upon by the Patient and DSMES team

OR only specific content areas:

- | | | |
|---|---|---|
| <input type="checkbox"/> Healthy Coping | <input type="checkbox"/> Glucose Monitoring | <input type="checkbox"/> Taking Medications |
| <input type="checkbox"/> Healthy Eating | <input type="checkbox"/> Reducing Risk | <input type="checkbox"/> Injection Training |
| <input type="checkbox"/> Being Active | <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Other: _____ |

SPECIAL NEEDS (OPTIONAL) | MEDICARE BENEFICIARIES

Please check reason IF more than 1 of 10 hours of INITIAL DSMES/T are being requested individually instead of in a group setting.

- | | | | |
|-----------------------------------|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Language | <input type="checkbox"/> Cognitive |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Psychosocial | <input type="checkbox"/> Transportation | <input type="checkbox"/> Other: _____ |

MEDICAL NUTRITION THERAPY

- Initial MNT Follow-up MNT Additional hours MNT for change in: (choose one)
- Medical Condition Treatment Diagnosis

SIGNATURE OF QUALIFIED PHYSICIAN OR ADVANCED PRACTICE PROFESSIONAL:

X _____ Date: _____

Practice Name: _____ Phone: _____ Fax: _____

Fax form to: 256-737-8006