J&B MEDICAL

50496 Pontiac Trail ● Wixom, MI 48393 ● **Phone:** (248) 560-1664 ● **Fax:** (248) 255-0158

BCBSM Type II Patient Empowerment Kit Prescription/Order Form

Name:______________________________
Date of Birth:_____________Gender:_____
Address:______________________________
____
Phone:______________________________
BCBSM ID:__________________________

Provider:___________________________
NPI:________________________________
License:_____________________________
Address:_____________________________
____
Phone:______________________________
Fax:________________________________

Supplies/Services Ordered:

I am enrolling the patient listed above in the BCBSM Type II Patient Empowerment Kit Program and understand that they will receive the following equipment and supplies:

- FreeStyle Libre 3 CGM System (6 sensors)
- Blood Pressure Monitor and Cuff (Wi-Fi Enabled)
- Scale (Wi-Fi Enabled)

1. **Diagnosis** (T2 Only)**:** ☐E11.9 controlled ☐E11.65 uncontrolled ☐E11.40 w/Neuropathy
   ☐ Other: ____
2. **Is this patient treated with insulin?** ☐No ☐Yes (If yes, patient does not qualify for the program)
3. **Patient's Email Address:**____________________________________
4. Patient's Mobile Device is compatible with LibreView (See **https://bit.ly/Libre3Compatibility**)
   ☐ Yes ☐ No, my patient requires a separate Reader for the Libre 3
5. **Frequency of CGM Use:**
   ☐2 weeks on, 6 weeks off ☐4 weeks on, 4 weeks off ☐Continuous for 12 weeks

Provider Signature / Attestation:

I certify that I am the provider identified below. I certify that the medical necessity information on this form is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact in that information may subject me to criminal or civil liability.

Signature:_______________________________________**Date:**_________________

Printed Name:____