

# ORDER FORM

## Diabetes Self-Management Education & Support (DSMES) and Medical Nutrition Therapy (MNT)

**MEDICARE COVERAGE:** Diabetes self-management education and 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 and DSMT are the same thing: DSMT is the name of the Medicare Benefit.

**DSMT:** 10 hours initial DSMES in 12-month period from the date of first encounter, plus 2 hours follow-up per calendar year with signed referral from the treating qualified provider (MD/DO, APRN, NP or PA) each year.

**MNT:** 3 hrs initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours with change in medical condition, treatment and/or diagnosis with signed referral from any physician (MD/DO).

### PATIENT INFORMATION:

Last Name	First Name	Middle	Date of Birth
Address	City	State	Zip Code
Home Phone	Cell Phone	Email Address	

### DIABETES DIAGNOSIS:

☐ Type 1 ☐ Type 2 ☐ Gestational Diagnosis Code: \_\_\_\_\_

### DSMES ORDERS:

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

☐ Initial DSMES \_\_\_\_\_ hours ☐ Follow-up DSMES \_\_\_\_\_ hours

### DSMES CONTENT AREAS:

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

**OR** only specific content areas:

<input checked="" type="checkbox"/> Healthy Coping	<input checked="" type="checkbox"/> Monitoring	<input checked="" type="checkbox"/> Taking Medication
<input checked="" type="checkbox"/> Healthy Eating	<input checked="" type="checkbox"/> Reducing Risk	<input type="checkbox"/> Injection Training
<input checked="" type="checkbox"/> Being Active	<input checked="" 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 DSMT 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:

Signature and NPI# of qualified provider certify that they are managing the beneficiary's diabetes care for DSMT referrals.

Date of signature:

Practice Name and Contact Info