

Type I (INSULIN DEPENDENT) DIABETES MELLITUS

Please have the following information completed by physician.

1. Specific ICD-9 Diagnosis:
 - a.
 - b.
 - c.
2. Age of member:
3. Age at date of diagnosis:
4. Please list current (including meds for all other diagnoses) medications with frequency, dosages, and length of time on medications:
 - a.
 - b.
 - c.
5. Please list past medications with dosages and reasons for stopping over the past 12 months (side effects, non-compliance, etc.)
 - a.
 - b.
 - c.
6. Please provide an all-inclusive list of follow-up with physicians (Family Practice, Internal Medicine, Endocrinologist, etc.) over the past 12 months. Please use a second page if needed.
7. Please list total number of hospitalizations related to diabetes with inclusive dates of most recent hospitalization. Please include ICU admissions:
 - a.
 - b.
 - c.
8. Any future medical/surgical plans, be as specific as possible (include when the follow-up is needed):
 - a.
 - b.
 - c.
9. Please provide date of last eye exam and results.
10. Please provide lab work for the last 12 months.
11. What type of glucometer does the individual use?
12. What symptoms does the individual have when blood sugar is low?
13. Does individual:
 - a. Use an insulin pump?
 - b. Count carbohydrates?
14. Does individual have a history of diabetic ketoacidosis (DKA)? If so, when was the last time and what caused it?
15. Copy of EFMP application and supplemental documents.
 - a. Copy of Letter of Category Assignment (if applicable)