

CCHP Provider referral to National Diabetes Prevention Program/Medicare Diabetes Prevention Program

Send to: Fax: 510-255-5196

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| PATIENT INFORMATION | | | |
|---|---|--|---|
| First name | Address | | |
| Last name | | | |
| Health insurance# | City | | |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | State | | |
| Birth date (/ /) | ZIP code | | |
| Email | Phone | | |
| By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program. | | | |
| PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER) | | | |
| Provider Name: | Facility: | | |
| NPI: | City | | |
| Staff Contact Name: | State | | |
| Contact Phone: | ZIP code | | |
| SCREENING INFORMATION | | | |
| Body Mass Index (BMI) | Eligibility = ≥ 24 (≥ 22 if Asian)* | | |
| Blood test (check one) <input type="checkbox"/> Hemoglobin A1C <input type="checkbox"/> Fasting Plasma Glucose <input type="checkbox"/> 2-hour plasma glucose (75 gm OGTT) Date of blood test (/ /): Must be within 1 year | <table border="1" style="width: 100%;"> <tr> <td> <p>Eligible range</p> <p>5.7–6.4%</p> <p>100–125 mg/dL</p> <p>140–199 mg/dL</p> </td> <td style="border: 2px solid black; padding: 5px;"> <p>MEDICARE ONLY (REQUIRED)</p> <p>Patient must have a qualifying blood test result (must be within 12 months of their planned Medicare DPP start date). Self-reporting is not allowed.</p> <ul style="list-style-type: none"> • Fill out the above lab values or provide a lab result print-out. • Lab printouts must include patient first name, last name, date of birth, health plan ID number, lab value and test date. </td> </tr> </table> | <p>Eligible range</p> <p>5.7–6.4%</p> <p>100–125 mg/dL</p> <p>140–199 mg/dL</p> | <p>MEDICARE ONLY (REQUIRED)</p> <p>Patient must have a qualifying blood test result (must be within 12 months of their planned Medicare DPP start date). Self-reporting is not allowed.</p> <ul style="list-style-type: none"> • Fill out the above lab values or provide a lab result print-out. • Lab printouts must include patient first name, last name, date of birth, health plan ID number, lab value and test date. |
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| Date | Practitioner signature | | |
| Patient Consent | <ol style="list-style-type: none"> 1. You are enrolling in a Diabetes Prevention Program (DPP) recognized by the federal government. 2. This program is based on sound research and is designed to help you avoid type-2 diabetes. 3. You understand that protected health information will be generated during your participation and that your privacy will be protected as required by all applicable laws. 4. You agree to enroll in this program and participate to obtain the health benefits. | | |
| Date | Patient signature | | |

*These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans and ≥ 25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility.