POLICY
This policy describes procedures for ordering diabetic testing supplies for community residents with Medicare Part B coverage as their primary insurance to ensure their timely delivery and continuous supply.

PROCEDURES
Medicare requires orders to be mail-in only placed through an approved supplier. Ageia communities use CCS Medical with Business Office Manager or Executive Director as persons authorized to and responsible for placing orders. To enroll a resident to receive mail-in diabetic testing supplies follow the steps below

- Fill out CCS Insurance Verification Form and Authorization for Release of Records of Information form
- Fax the required paperwork to CCS

After CCS enters the resident information into their system a CCS representative will be assigned to their case. The representative will contact the resident or Business Office Manager/Executive Director and resident’s physician to confirm the prescription and finalize supply order. Ageia communities use one kind of glucose meter and insulin pump, they are specified on CCS Insurance Verification Form. The process can take up to two weeks.

A re-order card will be mailed to the facility every 90 days for reorders. Business Office Manager/Executive Director will be responsible for reordering diabetic testing supplies.

New residents should have a minimum of two weeks of testing supplies upon admission to ensure timely delivery of new order.

FORMS
CCS Insurance Verification
Authorization for Release of Records
# Insurance Verification Form

Fax form with patient's signature to **1-800-306-9679** (toll-free fax)

ATTENTION: ALL SECTIONS MUST BE COMPLETED

## 1. PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Preferred Contact Method: [ ] Email [ ] Mail [ ] Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>Alt. Phone</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Languages: [ ] English [ ] Spanish [ ] Other</td>
</tr>
<tr>
<td>Relative/friend authorized on account</td>
<td>Phone</td>
</tr>
<tr>
<td>Preferred Glucose Monitor</td>
<td>Preferred Insulin Pump</td>
</tr>
</tbody>
</table>

Patient is interested in receiving: [ ] Monitor & testing supplies [ ] Testing supplies only [ ] Pump supplies & testing supplies [ ] Insulin pump and/or insulin pump supplies

I certify this form is true and complete. I authorize the release of all medical information necessary to approve or deny my insurance eligibility, claims, or rebates. I understand CCS Medical's participation in medical benefits for services provided and this certification is unconditional and necessary. I agree to return this completed form to CCS Medical at any time or any request or notice provided. I understand that I am expected to complete the form promptly and return it immediately. This form cannot be processed without a patient signature. (For Under 18, Parent or Guardian Signature / Si menor de 18 años, firma de padre o guardián.)

## 2. INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance Name (If any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #</td>
<td>Group #</td>
</tr>
</tbody>
</table>

## 3. PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Diabetes Doctor's Name</th>
<th>Phone #</th>
</tr>
</thead>
</table>

## 4. REFERRAL SOURCE

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Phone #</th>
</tr>
</thead>
</table>

This is a confidential message. It is intended solely for the person to whom it is addressed. It must be kept in strict confidence. If you receive this message in error, please forward it by toll-free fax to 1-800-306-9679 and destroy the copy you received. Thank you. ©2012 CCS Medical, Inc. All Rights Reserved. D06505 / 112
AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

PATIENT ID

SECTION A: I authorize the disclosure of my Personal Health Information (PHI) as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to ___________________________________________ (person) at ___________________________________________ (entity) to disclose my personal health information in the manner described herein.

Pt. Name: ___________________________________________
Pt. Address: ___________________________________________
Pt. Telephone: ___________________________________________

SECTION B: Personal Health Information to be Disclosed:

I authorize the person named above to access and use my PHI on file with CCS Medical. In addition, I specifically authorize the person named above to verify and authorize my medical supply shipments. I do not authorize this person to remove me from the program.

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke the authorization, I will submit a request in writing.

Expiration: This authorization expires at the time I change service levels that I am currently utilizing or upon my death. If at any point I change my level of service, I understand that I must complete a new authorization.

SIGNATURE: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my authorization that personal health information may be used and/or disclosed to the persons and/or organizations named in this form.

Signature: ___________________________________________ Date: ____________________
Printed Name: ___________________________________________
Witness: ___________________________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Accu-Chek® Nano SmartView

- 0.6 μL blood sample size
- 5 second test time
- 500 test memory
- Brilliant backlit display
- No Coding

Unistik®3 Comfort, single-use safety lancet, 28G

- Unistik®3 single-use lancets are safe, simple and virtually pain-free.
- Lancet is pre-set and does not require any cocking procedure. Just twist sterile cap and use. The needle point is hidden before use and automatically retracts after use to avoid accidental needle stick injuries and cross-infection.
- The unique, patented design features a side release button and pre-set lancet speed to ensure maximum comfort for the patient and the healthcare worker.
- Comfort Zone Technology® masks the pain of lancing with 8 raised dots that press against the finger and send a message of comfort to the brain. When the device is fired, the sensation of pain is masked by the stronger sensation of comfort, giving you a virtually painless stick.
- Suitable for delicate skin & frequent use.
**NovoFine® Pen Needles**

- NovoFine® 6mm and 8mm needles are thin and short, which may minimize needle-related anxiety.
- Thinner needles cause less pain, bleeding and bruising.
- NovoFine® needles are thin, ultra-sharp, electro-polished, silicone coated, and have a tapered point to improve comfort of injection.
- Thinner NovoFine® needles (higher G) reduce pain from injections compared to thicker needles with higher diameter.
Monoject® Ultra Comfort® Insulin Syringes

- Precision engineered for unparalleled accuracy, comfort and safety
- Available in:
  - 3/10cc, 1/2cc and 1cc sizes with half-unit markings on 3/10cc
  - 28 and 29 gauge, and 30 and 31 gauge short needle
- Latex free, individually wrapped and made in the USA

Needles