STATEMENT OF MEDICAL NEED

Patient Name:							DOB:
Address:							Phone:
City:			State				Zip:
ICD-9:		ICD-9		ICD-9		ICD-9	

Service/Intervention		
___ Additional Medication Counseling	___ Medication Review & Evaluation	___ Compliance Assessment
___ Injection Training	___ Device Training	___ Side Effect Analysis
Specify Device:	Specify Device: _____	___ FDA MedWatch® Report
	___ Body Fat Analysis (electrolipograph)	___ Stress/ADL Management
	___ Weight Monitoring	___ Other:

Asthma/COPD Coordination of Care	***Diabetes Coordination of Care***
___ General Asthma/COPD Education	___ Diabetes Mellitus Education (circle: type1 type 2)
___ Childhood Asthma Education	___ Lifestyle Modifications (diet, exercise, stress mgmt)
___ Pregnancy & Asthma Education	___ Complications of Diabetes
___ Environmental Control	___ Hypo/Hyperglycemia Management
___ Allergen Avoidance	___ Eye & Foot Care
___ Smoking & Asthma/COPD	___ Injection Device Training
___ MDI/Spacer Education	___ Blood Glucose Monitoring Training
___ Peak Flow Monitoring	___ Home Blood Glucose Monitoring Education
___ Asthma/COPD Care Diary	___ Glucose Monitoring Diary

Hyperlipidemia Coordination of Care	***Cardiovascular Coordination of Care***
___ Dyslipidemia Education	___ Cardiac Disease Education
___ Complications of Dyslipidemia	___ Hypertension Education
___ Risk Factors Education	___ Lifestyle Modifications (diet, exercise)
___ Lifestyle Modifications (diet, exercise, stress mgmt)	___ Sodium Restriction
___ Total Cholesterol Screening	___ Alcohol & Tobacco Elimination
___ Lipid Profile Monitoring (fasting)	___ Relaxation & Stress Reduction Techniques
___ Framingham Risk Assessment	___ Body Fat Analysis (electrolipograph)
___ Body Fat Analysis (electrolipograph)	___ Weight Monitoring
___ Weight Monitoring	___ Blood Pressure Monitoring
___ Blood Pressure Monitoring	___ Anticoagulation Monitoring (PT/INR)

Anticoagulation Coordination of Care	*Natural HRT Coordination of Care*
___ Anticoagulation Monitoring (PT/INR)	___ Lifestyle Modifications
___ Coagulation Meter Use Training	___ Medication Dosage Calculations
___ Detailed Anticoagulation Education	___ Dosage Form Review
___ Atrial Fibrillation Education	___ Dietary Concerns (calcium, Vitamin D, etc)
___ DVT/PE Education	___ OTC & Natural Product Education
___ Dietary Concerns	___ Risk Factors Education
___ OTC & Natural Product Education	___ Lipid Profile Monitoring (TC, HDL, LDL, TG)
___ Lifestyle Modifications (ADL, exercise)	___ Other:

I have asked _____ Pharmacy to evaluate this patient and recommend solutions to the patient's problem(s). Also, I request that a _____ pharmacist and/or nurse implement programs to correct the problem(s) under his/her control.

Goals and Duration of Intervention:

"I consider this program to be a necessary part of this patient's medical care."

Physician's Signature _____ Date _____

Printed Name _____ UPIN# _____

Patient Name: SS#

New Patient Home Visit Level II	99342
New Patient Home Visit Level II	99343
New Patient Home Visit Level IV	99344
Established Patient Home Visit Level II	99348
Established Patient Home Visit Level II	99349
New Patient Evaluation & Management (12-17 years)	99384
New Patient Evaluation & Management (18-39 years)	99385
New Patient Evaluation & Management (40-64 years)	99386
New Patient Evaluation & Management (>65 years)	99387
Established Patient Evaluation & Management (12-17 years)	99394
Established Patient Evaluation & Management (18-39 years)	99395
Established Patient Evaluation & Management (40-64 years)	99396
Established Patient Evaluation & Management (>65 years)	99397
Administration/Interpretation of HRA	99420
Unlisted Preventive Medicine Service	99429
Self-Care Consultation/Training (q 15 min)	97535
Group Education	99078
Services Requested After Hours	99050
Services Requested on Sundays & Holidays	99054
Other	

Laboratory	***CPT***
Routine Finger Stick	36415
Blood Glucose	82947
Total Cholesterol	82465
Lipid Profile	80061
HDL-C Only	83718
Triglycerides Only	84478
PT/INR	85610
Peak Expiratory Flow Rate	94750
Helicobacter Pylori IgC Antibody Test	86677
Percentage Body Fat Analysis	
Other	

Saliva Tests Performed	***CPT***
Estradiol	82670
Estriol	82677
Estrone	82679
Progesterone	84144
Testosterone	84403
DHEA-Sulfate	82626
Cortisol	*82533*
Cortisol AM/PM (inc 82533 x2)	80400
Cortisol x4 (inc 82533x4)	80418
Androstenedione	82157

Date of Service:	
Patient Name:	
Patient Phone:	

Problems Detected	***Fee***
Product Needed, Not Prescribed	
Product Prescribed, Not Needed	
Ingredient Duplication	
Therapeutic Overlap	
Non-Formulary Product	
Clarification	
Cost Prohibitive	
Prescribed Dose Above Maximum	
Prescribed Dose Below Minimum	
Prescribed Schedule Above Maximum	
Prescribed Schedule Below Minimum	
Prescribed Duration Above Maximum	
Prescribed Duration Below Minimum	
Prescribed Product Contraindicated	
Patient Allergy to Prescribed Product	
Drug-Drug Interaction	
Drug Disease Interaction	
Other	

Provider Actions	***Fee***
Contact Prescriber/Prescriber's Agent	
Consult with other Health Care Professional	
Research Reference Materials	
Counsel Patient/Patient's Care Giver	
Develop/Initiate Adherence Monitoring Tools	
Provide Patient Education/Demonstration	
Other	

Miscellaneous	**CPT**
Educational Supplies	99071
Analysis of Information Stored in a Computer	99090
Paraffin Bath	97018
Massage Therapy	97124
Other	

I certify that the above services have been rendered and the fees submitted are those that have been charged to the indicated patient.

Provider Signature ***Date***

License # _____

Patient Signature **Date**

Total $ _____