Print Reset

Arkansas Medicaid Durable Medical Equipment (DME)
Medical Prior Request Form for Continuous Glucose Monitors (CGM)

Fax form to: 800-424-7976 For questions, call: 800-424-7895

Please attach any additional documentation that is important for the review (e.g., chart notes or lab data), to support the prior authorization.

Prior Authorization Priority: ☐ Standard ☐ Expedited

Prior Authorization Type: ☐ New Request ☐ Renewal Request ☐ Change to Existing Approval

If selecting change to existing, please document the prior authorization number: _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID: _____ Date of Birth: _____

DME BILLING PROVIDER INFORMATION

DME Billing Provider Name: _____

DME Phone Number: _____ DME Fax Number: _____

DME Billing Provider NPI: _____ DME Billing Provider Medicaid ID: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber NPI: _____

PRODUCT/SERVICE LINE INFORMATION

Continuous Glucose Monitor Sensor Procedure Code: _____

Product Name (e.g., Dexcom G7, or Freestyle Libre 3): _____

Modifier (Up to 4): _____ _____ _____ _____

Total HCPCS Units Requested for PA Duration: _____

Start Date: _____ End Date: _____

Note: If modifiers are included in this request they must also be included in the claim submitted for this service.

Beneficiary Name (Last, First): _____

Continuous Glucose Monitor Receiver/Reader Procedure Code, if applicable: _____

Product Name: _____

Modifier (Up to 4): _____ _____ _____ _____

Total HCPCS Units Requested for PA duration: _____

Start Date: _____ End Date: _____

Continuous Glucose Monitor Transmitter Procedure Code, if Applicable: _____

Product Name: _____

Modifier (Up to 4): _____ _____ _____ _____

Total HCPCS Units Requested for PA Duration: _____

Start Date: _____ End Date: _____

DIAGNOSIS AND MEDICAL INFORMATION

1. What are the beneficiary's relevant diagnoses and ICD-10 codes?

   Diagnoses: _____

   ICD-10 codes: _____

What additional clinical information do you have that is relevant to this request for prior authorization? Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased dose, as well as whether the beneficiary has any contraindications to the Arkansas Medicaid preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information that is related to exigent circumstances or required under state and federal laws.

ATTESTATION

It is understood and the DME provider attests that:

- **The beneficiary (or authorized representative) has been informed they will receive all CGM supplies exclusively from the DME provider named above.**
- **The beneficiary has been informed that they will no longer obtain CGM supplies from their pharmacy or any other provider.**
- **This information has been supplied to the beneficiary's pharmacy, if the beneficiary was previously receiving CGM supplies from the pharmacy.**

Name of Pharmacy: _____ **Date Notified:** _____

Beneficiary Name (Last, First): _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that Arkansas Medicaid or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

DME Provider Signature: _____ **Date:** _____

(By signature, the DME provider confirms the above information is accurate and verifiable by patient records.)

Printed Name and Title: _____

Retain this documentation in the patient's medical records. Falsification of medical records is liable to the U.S. government for a civil penalty of not less than $5,000 and not more the $10,000, plus 3 times the amount of damages that the government sustains because of the act of that person. [42 U.S.C.A. § 3729(a)].

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents.

FORM INSTRUCTIONS

- Complete one form per beneficiary.
- Fill out all applicable sections on all pages completely and legibly before prior authorization can be made.
- Retain a copy of this form in the beneficiary's record, as all requests and chart notes are subject to audit.
- Incomplete forms may result in a delay in prior authorization review or a denial of the prior authorization request.
- This form and authority for DME providers to provide CGM is per Act 857 of 2025 which is only for continuous glucose monitor related diabetic supplies and not for other supplies such as blood glucose meters and strips.