

INCOMPLETE FORM MAY DELAY PROCESSING

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Address:			Office Address:		
City:	State:	Zip:	City:	State:	Zip:
Requestor Information (required if not requested by the member or prescriber)					
<p>An individual other than the member or prescriber (such as a family member or friend) may make a request on behalf of the member provided that the individual is a representative. Documentation must be attached showing the individual's authority to represent the member a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact Zing member services or 1-800-Medicare.</p>					
Requestor Name:			Requestor Phone:		
Requestor Address:			Relationship to Member:		
City:		State:		Zip:	
Medication and Diagnosis Information					
Medication Requested:			Diagnosis Code:		
Strength & Route of Administration:			Quantity Prescribed:		
Directions for Use (including frequency and expected length of therapy):					

Please answer the questions below

1. Is this request for an expedited review? Yes No
If the requestor or prescriber believe that waiting up to 72 hours for a standard decision could seriously harm the member's life, health, or ability to regain maximum function, an expedited decision (within 24 hours) can be requested.
2. Does the patient have diabetes, gestational diabetes, prediabetes or on a concomitant drug that may affect blood sugar levels? Yes No
3. Please indicate the requested brand of diabetes testing supply:
 Contour OneTouch ReliOn True Metrix
 Other (Please specify): _____
4. Has the patient tried Accu-Chek or FreeStyle brand diabetes testing supplies? Yes No
If YES, please describe the diabetes testing supply failure: _____

If NO, please describe the clinical rational or patient limitations to the covered brand products:

Submission Information

Signature: _____ Date: _____

Please Note:

- This request may be denied or dismissed unless all required information is received
- For questions, please contact Zing Customer Service at 1-866-946-4458
- The prescriber's office will receive a response via fax
- Request forms can be submitted via fax, email or mail:

Fax Number: 1-844-946-4458

Email: prior_auth@myzinghealth.com

Mail: Zing Health

Attn: Prior Authorization

P.O. Box 6589

Chicago, IL 60606

Authorization Period: 1 Year – subject to formulary change and member eligibility.

*** PLEASE FAX COMPLETED FORM TO: 844-946-4458 OR EMAIL TO [PRIOR_AUTH@MYZINGHEALTH.COM](mailto:prior_auth@myzinghealth.com) ***

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Diabetes Testing Supplies
Medicare Part B Coverage Request Form

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