Zing HEALTH

Diabetes Testing Supplies

Medicare Part B Coverage Request Form

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)

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.

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:
   ☐ Accu-Chek ☐ Contour ☐ ReliOn ☐ True Metrix
   ☐ Other (Please specify): _____
4. Has the patient tried FreeStyle or OneTouch 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 ***