Diabetes Care Form

Please fax completed forms to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com** and save a copy in the patient's medical record. If the form is filled out by an office or clinical support staff member, it must be routed back to the provider for follow-up and sign off.

Patient Name: _____ DOB: _____ ID#: _____

Date Vitals Collected: ___/___/____ Blood Pressure: ____/_____

Diabetic Labs Completed in 2022		
Hemoglobin A1c Testing (HbA1c) **Date**: ___ / _____ /_____ **Result**: _____	Estimated Glomerular Filtration Rate (eGFR) **Date**: ___ / _____ /_____ **Result**: _____	Urine Creatinine Test **Date**: ___ / _____ /_____ **Result**: _____ Urine Albumin Test **Date**: ___ / _____ /_____ **Result**: _____

Retinal or Dilated Eye Exam Completed in 2021 (negative results only) or 2022 (positive or negative results)
Date Exam Completed: _____ / _____ / _____ **__ Negative for Retinopathy; Normal Retina** **__ Positive for Retinopathy** **__ Bilateral Eye Enucleation (anytime in member's history)** **Place of Service: _____** **Phone: _____ Fax: _____** **Name of Eye Care Professional: _____Credentials: _____**

Provider Name and Credentials (Print): _____

Provider Signature: _____ Date: _____/_____/_____

Meridian, Wellcare, and Ambetter are affiliated products serving Medicaid, Medicare, and Health Insurance Marketplace members respectively. The information presented here is representative of our network of products. If you have any questions, please contact Provider Relations.
