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 2024		
Hemoglobin A1c Testing (HbA1c) **Date**: __ /__ /_____ **Result**: __________ Glucose Management Indicator Testing (GMI) **Date:** __/__/____ **Result:** _________	Estimated Glomerular Filtration Rate (eGFR) **Date**: __ /__ /_____ **Result**: __________	Urine Creatinine Test **Date**: __ /__ /____ **Result**: __________ Urine Albumin Test **Date**: __ /__ /_____ **Result**: __________ Urine Albumin-Creatinine Ratio (uACR) **Date**: __ /__ /_____ **Result**: __________

Retinal or Dilated Eye Exam Completed in 2023 (negative results only) or 2024 (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: _______________**

Eye Care Professional 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.

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