



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: ___/___/___
<input type="checkbox"/> Negative for Retinopathy; Normal Retina <input type="checkbox"/> Positive for Retinopathy <input type="checkbox"/> 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.