Dexcom Canada, Inc.
501 – 4445 Lougheed Hwy
Burnaby, BC V5C 0E4

Dexcom®

Certificate of Medical Necessity
Continuous Glucose Monitoring (CGM) System

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Province: _____ Postal Code: _____

Email (optional): _____

STATEMENT OF MEDICAL NECESSITY

Diabetes Type: ☐ Type 1 ☐ Type 2 ☐ Gestational

Diabetes Therapy: ☐ Multiple Daily Injections (_____ injections per day)

☐ SMBG tests (_____ tests per day)

☐ Insulin pump - (start date: _____/ _____/ _____)

OPTIONAL
HbA1c results only required for some insurance providers: Manulife, OTIP, Johnson Group, and Manion-Wilkins.

HbA1c Result #1: _____ Date: _____

HbA1c Result #2: _____ Date: _____

HbA1c Result #3: _____ Date: _____

SUPPORTING CLINICAL INDICATIONS

☐ Motivated to achieve and maintain improved glycemic control

☐ Demonstrated ability to self-monitor blood glucose levels

☐ Demonstrated ability to self-manage glucose using insulin (long acting, fast acting)

☐ History of hypoglycemia unawareness

☐ History of severe glycemic excursions

☐ History of nocturnal hypoglycemia

☐ Recurring episodes of severe hypoglycemia

☐ Unexplained, severe hypoglycemia episodes requiring external assistance for recovery

☐ Other: _____

PHYSICIAN INFORMATION

Physician Name: _____ Office Contact: _____

Hospital/Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ Province: _____ Postal Code: _____

Email (optional): _____

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring (CGM) System, Dexcom CGM Sensors, Dexcom CGM Replacement Transmitter or Dexcom CGM Replacement Receiver and all associated diabetes supplies to be provided by Dexcom Canada, Inc. NO SUBSTITUTIONS.

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to Civil or criminal liability.

Signature: _____ Date: _____

Please return by email to CA.Sales.dc@Dexcom.com, by toll free fax to 1-844-348-0784
or by regular mail to: Dexcom Canada, Inc. 501 – 4445 Lougheed Hwy, Burnaby, BC V5C 0E4