



...Giving you a better quality of life

Enrollment Form
Phone: 651-260-2903

First Name: _____ Last Name _____ MI: _____

Birth Date: _____ M F Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name as it appears on Medicare Card: _____

Medicare ID Number: _____ A&B Effective _____

Medicaid Number (if applicable): _____

Current Primary Insurance Company: _____

ID Number: _____

Secondary or Supp. Ins. Company (if applicable): _____

ID Number: _____

If starting a new plan in the future: Name of New Insurance Company _____

Effective Date of New Insurance _____

Primary Diabetic Doctor (First & Last Name): _____

Doctor Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Date of Last Visit: _____ Fax #: _____

of times per day your Dr. wants you to test? 1 2 3 4 5 6 - Other _____

of Supplies on Hand: _____

What meter do you currently use? _____ New Meter: _____

Do you need a talking Meter? YES / NO Spanish Speaking? YES / NO

Insulin Dependent: YES / NO

I authorize an American Diabetes Alliance-approved supplier to contact me by telephone to discuss my diabetic testing needs and course of treatment.

Your Signature: _____ Today's Date: _____

Office Use Only	
Agents Name: _____	Today's Date: _____
Agents Signature: _____	ID# _____
Submit by Fax: 651-414-9993	Doctor's NPI# _____