



\* Si usted necessita esta informacion en espanol por favor llame al 1-866-593-2358

<<Date>>

<<Member First Name>> <<Member Last Name>>

<<Address>>

<<City>> <<State>> <<Postal Code>>

PreferredOne would like to help you get more involved in your child's health care. Our records show that your child may have diabetes or high blood sugar. ( If this is incorrect, please call the number below and let us know.) **Getting involved is up to you.**

Below is a list of educational material to help you learn more about your child's diabetes. Please check off the brochure(s) that you would like to receive. Tear off the bottom portion of this letter and mail it back to us. Use the enclosed postage paid envelope. We will send the educational materials to you.

Also, we would like to learn more about your child's health care needs. Please fill out the enclosed Member Questionnaire and mail it back to us. You can use the same envelope that you mail your request for educational materials in.

If you want to speak with one of our nurses about our Program, please **call toll-free 1-866-593-2358**. (If you are a TTY/TTD user, please call 1-877-247-6272.) Our nurses are available Monday-Friday 8:00 am-5:00 pm EST.

Working together as a team, we can make a difference!

Thank you,  
PreferredOne



Member Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

- |   |  |                                      |   |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> Glucose Monitoring | <input type="checkbox"/> HbA1c               | <input type="checkbox"/> Eye Care    | <input type="checkbox"/> Carbohydrate   |
| <input type="checkbox"/> Insulin Pump       | <input type="checkbox"/> Overview of         | <input type="checkbox"/> Feet Care   | <input type="checkbox"/> Counting       |
| <input type="checkbox"/> Insulin            | <input type="checkbox"/> Complications       | <input type="checkbox"/> Kidney Care | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Understanding Your | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nutrition   | <input type="checkbox"/> Issues         |
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Smoking Cessation   | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Sick Day       |
| <input type="checkbox"/> Depression         |  |                                      |   |