

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: ___/___/_____

SURGICAL TYPE

- Partial Mastectomy
- RT** **LT** **BI LATERAL**
- Mastectomy
- RT** **LT** **BI LATERAL**
- Reconstruction
- RT** **LT** **BI LATERAL**
- This patient is requesting that you contact them to set up an appointment.
Please contact:

In order to have complete records indicating Medical Necessity for each of our patients we ask you to complete the following prescription with **DOCTOR'S SIGNATURE - NPI - DATE - DIAGNOSIS CODE.**
We cannot dispense product without this RX completed. Thank You!



Doctor's Printed Name: _____ NPI#: _____
 Doctor's Signature: _____ Date: _____
 Diagnosis Code: _____ Right Side: _____ EXPIRES: _____
 Left Side: _____

COMPRESSION

- L8010 Lymphedema Sleeve QTY___ No. of Refills _____
- A6549 Compression Garment QTY___ No. of Refills _____
- A4465 Non-elastic Binder for Extremity QTY___ No. of Refills _____

BREAST PROSTHESIS

- L8015 Post-Surgical Camisole with Mastectomy Form QTY___ No. of Refills _____
- L8020 Post-Surgical/Non-Silicone Breast Prosthesis QTY___ No. of Refills _____
- L8030 Silicone Breast Prosthesis QTY___ No. of Refills _____
- L8032 Nipple Prosthesis, Reusable, Any Type QTY___ No. of Refills _____
- L8035 Custom Breast Prosthesis QTY___ No. of Refills _____

MASTECTOMY BRA

- L8000 Mastectomy Bra without integrated Breast Form, Any Size, Any Type QTY___ No. of Refills _____

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