PH SERVICES

Mastectomy ▪ Compression

PRESCRIPTION / LETTER OF MEDICAL NECESSITY

Patient Information:

Name:	DOB:

ICD 10 Diagnosis Code ☐ I89.0 ☐ Q82.0 ☐ I97.2 ☐ Other _____

☐ Day Compression ☐ Ready Made ☐ Custom ☐ Eligible Qty 6 ☐ Other _____

Extremity
- ☐ LEFT
- ☐ RIGHT
- ☐ BILATERAL

Compression
- ☐ 15-20
- ☐ 20-30
- ☐ 30-40
- ☐ 40-50

Upper Extremity
- ☐ GAUNTLET
- ☐ GLOVE
- ☐ ARM SLEEVE
- ☐ COMPRESSION BRA
- ☐ VEST
- ☐ HEAD AND NECK
- ☐ BREAST SWELL PAD

Lower Extremity
- ☐ TOE CAPS
- ☐ PANTY
- ☐ CALF
- ☐ THIGH
- ☐ LEGGING/CAPRI
- ☐ BIKER/GENITAL SHORT
- ☐ GENTIAL SWELL PAD

Custom Ancillaries
- ☐ SiliconeTB
- ☐ ClosedToe
- ☐ Silk Lining qty ____
- ☐ Steep Oblique
- ☐ Knit Marks qty ____
- ☐ Lymph Pad qty ____
- ☐ Thumb Webbing
- ☐ _____

☐ Ready Made ☐ Night Compression ☐ Eligible Qty 2 ☐ Velcro Wraps ☐ Eligible Qty 6

☐ Custom

Extremity
- ☐ LEFT
- ☐ RIGHT
- ☐ BILATERAL

- ☐ GAUNTLET
- ☐ GLOVE
- ☐ ARM SLEEVE
- ☐ VEST
- ☐ CALF
- ☐ THIGH
- ☐ FOOT/ANKLE
- ☐ PANTS/CAPRI

Nightime Ancillaries
- ☐ Pull Up Loops
- ☐ Zipper
- ☐ Digital Spacers
- ☐ Non Skid Pad
- ☐ Velcro Panels
- ☐ _____

- ☐ Below Knee
- ☐ Above Knee
- ☐ Full Leg
- ☐ Foot/Ankle
- ☐ Arm
- ☐ Hand
- ☐ _____

- ☐ Basic Liner
- ☐ Hybrid Liner
- ☐ Class 1
- ☐ Class 2

DURATION: ☐ 99 MONTHS / PERMANENT USE ☐ Other _____

Treatment Plan:

The treatment plan for this Rx is for compression garments to be worn during the day/night on a daily basis as prescribed by the physician.

Certification of Medical Necessity:

The medical equipment herein prescribed is medically necessary to: apply sustainable, comfortable compression for post-surgical needs, control and contain lymphedema and or increase blood flow to the heart using gradient compression.

MD Certification:

Physcian Name:	**NPI:**	
Address:	**Specialty:**	
City:	**State:**	**Zip:**
Phone:	**Fax:**	

_____

(Physician Signature) (Date)

11901 West Parmer Lane, Suite 210, Cedar Park, TX 78613, 512) 986-6291 ▪ Fax (512) 986-6330 ▪ www.phservnet.com