PH SERVICES

Mastectomy ▪ Compression

PRESCRIPTION / LETTER OF MEDICAL NECESSITY
POST BREAST SURGERY

Patient Information:

Name:	DOB:
Diagnosis:	☐ Left ☐ Right ☐ Bilateral

*Medicare will not accept C50.419 or C50.919, they will pay for 6 bras per year, 1 Silicone prosthesis every 2 years OR 1 Leisure prosthesis every 6 months per side
☐ Breast Prosthesis – Silicone or equal (L8030) _____ Quantity
☐ Foam Prosthesis – Post surgery or leisure (L8020) _____ Quantity
☐ Mastectomy Bra(s) (L8000) _____ Quantity
☐ Nipple Prosthesis (L8032) _____ Quantity
Patient Medical Records must contain the following in order to bill the insurance company: Patient will have an ongoing need to to wear and replace the (LT, RT, or BIL) prosthesis, nipples and bras due to (mastectomy/lumpectomy) from (LT, RT or BIL) breast cancer ****Letter of Medical Necessity is not accepted by insurance companies. The note must be in the patient's medical Records.**

Length of Need: ☐ 12 Months ☐ Indefinitely ☐ Other _____

Please circle all that apply: Weight (Gain / Loss) : _____Lbs. Loss / Irreparable Damage / Visible wear to form

Replacement Breast form or bra(s) due to

_____

MD Certification:

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

*Physcian Name above must be legible

_____

(Physician Signature) (Date)

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