Mastectomy ▪ Compression ▪ Specialty Medical Equipment

PRESCRIPTION / LETTER OF MEDICAL NECESSITY

Patient Information:

Name:	DOB:
Diagnosis Code(s):	

☐ **Day Compression** ☐ Ready Made ☐ Custom

Extremity	Compression	Upper Extremity	Lower Extremity	
☐ LEFT ☐ RIGHT ☐ BILATERAL	☐ 16-20 ☐ 20-30 ☐ 30-40 ☐ 40-50	☐ GAUNTLET ☐ GLOVE ☐ ARM SLEEVE ☐ VEST ☐ COMPRESSION BRA	☐ TOE CAPS ☐ ANKLE ☐ CALF ☐ THIGH ☐ THIGH W/WAIST	☐ PANTY ☐ BIKER SHORTS ☐ LEGGINGS ☐ Capri

☐ **Night Compression** ☐ **Alternative Velcro Wraps**

Extremity	Upper Extremity	Lower Extremity
☐ LEFT ☐ RIGHT ☐ BILATERAL	☐ GAUNTLET ☐ GLOVE ☐ ARM SLEEVE ☐ VEST	☐ CALF ☐ THIGH ☐ PANTS

Ancillaries for Velcro Garments:

☐ Liners ☐ Foam Liners

☐ Silver Liners ☐ Hybrid (Compression in foot)

Liner Class _____

DURATION: ☐ 99 MONTHS / PERMANENT USE ☐ **Is a specific vendor requested?** _____

Treatment Plan:

The treatment plan for this Rx is for compression garments to be worn during the day 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)

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