



Mastectomy • Compression • Specialty Medical Equipment

## PRESCRIPTION / LETTER OF MEDICAL NECESSITY

### Patient Information:

Name:	DOB:
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Diagnosis Code(s):
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<input type="checkbox"/> Day Compression		<input type="checkbox"/> Ready Made	<input type="checkbox"/> Custom
Extremity	Compression	Upper Extremity	Lower Extremity
<input type="checkbox"/> LEFT	<input type="checkbox"/> 16-20	<input type="checkbox"/> GAUNTLET	<input type="checkbox"/> TOE CAPS
<input type="checkbox"/> RIGHT	<input type="checkbox"/> 20-30	<input type="checkbox"/> GLOVE	<input type="checkbox"/> ANKLE
<input type="checkbox"/> BILATERAL	<input type="checkbox"/> 30-40	<input type="checkbox"/> ARM SLEEVE	<input type="checkbox"/> CALF
	<input type="checkbox"/> 40-50	<input type="checkbox"/> VEST	<input type="checkbox"/> THIGH
		<input type="checkbox"/> COMPRESSION BRA	<input type="checkbox"/> THIGH W/WAIST
			<input type="checkbox"/> PANTY
			<input type="checkbox"/> BIKER SHORTS
			<input type="checkbox"/> LEGGINGS
			<input type="checkbox"/> Capri

<input type="checkbox"/> Night Compression		<input type="checkbox"/> Alternative Velcro Wraps	<b>Ancillaries for Velcro Garments:</b>
Extremity	Upper Extremity	Lower Extremity	<input type="checkbox"/> Liners
<input type="checkbox"/> LEFT	<input type="checkbox"/> GAUNTLET	<input type="checkbox"/> CALF	<input type="checkbox"/> Foam Liners
<input type="checkbox"/> RIGHT	<input type="checkbox"/> GLOVE	<input type="checkbox"/> THIGH	<input type="checkbox"/> Silver Liners
<input type="checkbox"/> BILATERAL	<input type="checkbox"/> ARM SLEEVE	<input type="checkbox"/> PANTS	<input type="checkbox"/> Hybrid <small>(Compression in foot)</small>
	<input type="checkbox"/> VEST		Liner Class _____

<b>DURATION:</b> <input type="checkbox"/> 99 MONTHS / PERMANENT USE <input type="checkbox"/> Is a specific vendor requested? _____
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### 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:

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

\_\_\_\_\_  
(Physician Signature)

\_\_\_\_\_  
(Date)