Mastectomy ▪ Compression ▪ Specialty Medical Equipment

PRESCRIPTION / LETTER OF MEDICAL NECESSITY
POST BREAST SURGERY

Patient Information:

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

☐ Post-Surgical Garment – Camisole (L8015)	_____ Quantity
☐ Breast Prosthesis – Silicone or equal (L8030)	_____ Quantity
☐ Foam Prosthesis – Post surgery or leisure (L8020)	_____ Quantity
☐ Mastectomy Bra(s) (L8000)	_____ Quantity
☐ Nipple Prosthesis (L8032)	_____ Quantity
☐ Silicone Scar Reduction Sheets	_____ Quantity
☐ Compression Bra (E1399) with Bra Extender/s and/or Drain Pocket/s.	_____ Quantity

Will Need For: ☐ Six Months ☐ 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:**	

_____

(Physician Signature) (Date)

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