Pink Promises Boutique

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POST-MASTECTOMY E-Z SCRIPT

Please fax your patient's insurance and demographic information along with this form.

Start Date: _____ Acct #:_____
Patient Name: _____ DOB:_____
Patient Phone #: _____ Ordered By: _____
Address:_____ Height: _____ Weight: _____
Diagnosis/Diagnosis Code:_____ Duration of Need:_____

POST MASTECTOMY SUPPLIES:

❑ L8000 Bra
twelve per year

❑ L8001 Perma-Form Uni-Lat Bra
two per year

❑ L8002 Perma-Form Bi-Lat Bra
two per year

❑ L8015 Post-Surgery Garment
one per surgery

❑ L8020 Breast Form, Non-Silicone
two per year ❑ Left ❑ Right ❑ Bilateral

❑ L8030 Breast Form, Silicone
one every other year ❑ Left ❑ Right ❑ Bilateral

Please note, a patient qualifies for the above ordered supplies with a DX of Breast Cancer **174.0-174.9,233.0 and/or Acquired Absence of Breast **V45.71.***

COMPRESSION GARMENT

❑ Arm Sleeve L8010 ❑ Left ❑ Right ❑ Bilateral
❑ Hand Gauntlet E1399 ❑ Left ❑ Right ❑ Bilateral

❑ *Compression Strength:*_____

❑ LYMPHEDEMA PUMP E0651

❑ Leg Sleeve E0667 1 every 5 years ❑ Left ❑ Right ❑ Bilateral

❑ Arm Sleeve E0668 1 every 5 years ❑ Left ❑ Right ❑ Bilateral

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: _____ DATE: _____/_____/_____

Printed Name: _____ Address: _____

Phone: _____ UPIN/ NPI #: _____ City/State/Zip: _____

Revised: 6-27-12