



**Pink Promises Boutique**

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**Jacqueline Martin, CFM**  
Post Mastectomy Specialist

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

**POST-MASTECTOMY E-Z SCRIPT**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Side of Surgery: \_\_\_\_\_

Start date of order: \_\_\_\_\_

**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
- L8030 Breast Form, Silicone  
one every other year

Diagnosis: **ICD-9 (in # Form)** \_\_\_\_\_

*\*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.*

Duration of Need: \_\_\_\_\_

*(These supplies are LIFETIME PURCHASE, 99 MONTHS)*

**COMPRESSION GARMENT**

- Arm Sleeve
- Hand Gauntlet
- Compression Bra

Diagnosis: \_\_\_\_\_

Duration of Need: \_\_\_\_\_

*(These supplies are LIFETIME PURCHASE, 99 MONTHS)*

Compression Strength: \_\_\_\_\_

**LYMPHEDEMA PUMP**

- Leg Sleeve       Vest
- Arm Sleeve

Diagnosis: \_\_\_\_\_

Duration of Need: \_\_\_\_\_

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: \_\_\_\_\_