BOARDMAN•MEDICAL•SUPPLY
BMS
COMPANY, INC.
Pink Promises

Pink Promises Boutique

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BOARDMAN
404 Boardman-Canfield Rd.
Boardman, OH 44512

GIRARD
300 N. State St.
Girard, OH 44420

SHARON
719 E. State St.
Sharon, PA 16146

TWINSBURG
8900 Darrow Rd.
Twinsburg, OH 44087

POST-MASTECTOMY E-Z SCRIPT

****Please fax your patient's insurance information, demographics and chart notes with this form.****

Start Date: _____ Acct #:_____

Patient Name: _____ DOB:_____

Patient Phone #: _____ Ordered By: _____

Address:_____ Height: _____ Weight: _____

ICD -10 Code:_____ Duration of Need:_____

POST MASTECTOMY SUPPLIES:

❑ L8000 Bra
twelve per year

❑ L8001 Perma-Form Uni-Lat Bra
Quantity _____ per yr.

❑ L8001 Uni-Lat compression Bra w/ Integrated Breast Form
Quantity _____ per yr.

❑ L8002 Perma-Form Bi-Lat Bra
Quantity _____ per yr.

❑ L8015 Post-Surgery Garment
Quantity _____ per yr.

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

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

❑ L8032 Nipple prosthesis adhesive
one every 3 months ❑ Left ❑ Right ❑ Bilateral

**Please note, a patient qualifies for the above ordered supplies with ICD -10 code (List attached)*

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

Revised: 4-26-16