COMPRESSION CARE

Referral Cover Sheet

To: Compression Care
Fax: (615) 807-3334
Phone: (615) 583-2273

Referring Therapist: _____
Email: _____
Phone: _____ **Fax:** _____

Date: _____ **Patient Name:** _____

Subject: ☐ **Full Referral** ☐ **Benefit Verification Only** (Choose One)

To request verification or order from Compression Care:

(please send all you can of the required information as this will help speed the process)

☐ **Demographics Sheet**
- All Patient Data Including insurance info, phone number, and email address if available.
- Full name of Referring Physician should be included on demographics.

☐ **Insurance Card: Clear Copy Of Front AND Back**

☐ **Compression RX**
- Must be signed by the Referring Provider. (MD, DO, NP, PA)
- **OR** Therapy notes (POC) If signed by the referring provider(MD, DO, NP, PA). Notes must include medical necessity for compression garments.
- Script must specify the garment requested including CCL & Extremity treated. "Compression garment" (or "stocking") is not specific enough.

☐ **Detailed Garment Specs OR Complete Custom Measurement Form**
- Detailed order must include Brand, Style, CCL, Color, Open or Closed Toe, Size, and Quantity.
- Custom measurement form on manufacturer's form.

☐ **Custom Measurements Attached**

Please Note:

- The POC is not necessary unless it functions as the RX **AND** is signed by the referring provider.
- Garment specifications must be listed below as we cannot read nor interpret POCs
- For Medicare Advantage Plans we are currently only filing Humana, Aetna, and Cigna at this time.

Garment Specifications: (Brand, Style, CCL, Color, Open or Closed Toe, Size, and Quantity)

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You may also E-Mail this information to: **Referrals@CompressionCare.com**