RX / LETTER OF MEDICAL NECESSITY

PATIENT INFORMATION		
Name	MBI (If Medicare)	
Date	Date of Birth	Gender ■ Male ☐ Female
Diagnosis Code ☐ I97.2 Post-Mastectomy Lymphedema Syndrome ☐ I89.0 Other Lymphedema (praecox, secondary, acquired/chronic, elephantitis) ☐ I87.2 Venus Insufficiency (nos periph) ☐ Other _____		

PHYSICIAN AUTHORIZATION	
Referring Physician Name	
► **Physician Signature**	
NPI	Date

GARMENT INFORMATION	
Compression Strength (mmHG) ☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50	☐ Ready to Wear ☐ Custom ☐ Silicone Band
Upper Extremity ☐ RT ☐ LT ☐ Sleeve ☐ Glove ☐ Head/Neck ☐ Torso	Lower Extremity ☐ RT ☐ LT ☐ Knee ☐ Thigh ☐ Panty/Capri ☐ Foot
Garment Notes / Efficacy Aids Donning Aids Compliance Kit.	
General Description Permanent use of compression garments for lymphedema to be worn during the day and/or night on a daily basis per body part as determined by, and the quantities recommended by, the plan of care from the physical therapist and DMEPOS.	

PLEASE E-MAIL THIS WRITTEN ORDER AND CURRENT OFFICE NOTES TO REFERRALS@COMPRESSIONCARE.COM OR FAX TO (615) 807-3334