# CERTIFICATE OF MEDICAL NECESSITY & PHYSICIAN ORDER FOR DME SUPPLIES

**FAX OR EMAIL TO: 615-595-9053 INFO@PRETTYINPINKBOUTIQUE.COM**

## PATIENT INFORMATION

| | |
|---|---|
| FULL NAME | PHONE |
| ADDRESS CITY | STATE ZIPCODE |
| EMAIL | DATE OF BIRTH mm/dd/yyyy |

## INSURANCE INFORMATION

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| NAME OF INSURANCE | NAME OF INSURANCE |
| POLICY # | POLICY # |
| GROUP # | GROUP # |
| PATIENT MEDICARE ID (MBI): (IF APPLICABLE) | |

## DME PROVIDER INFORMATION

**Name: Some Other Company, Inc dba Pretty In Pink Boutique** **NPI: 1831116631**
**Address: 3343 Aspen Grove Drive Suite 200 Franklin, TN 37067** **Phone: 615-777-7456 Fax: 615-595-9053**

## DIAGNOSIS AND MEDICAL NEED INFORMATION

PLEASE INCLUDE THE FOLLOWING SUPPORTING DOCUMENTS ALONG WITH THIS FORM

- ☐ FACESHEET
- ☐ INSURANCE CARD (FRONT AND BACK)
- ☐ PLAN OF CARE
- ☐ CLINICAL/OFFICE NOTES
- ☐ COMPLETE MEDICAL RECORDS
- ☐ ADD'L INFORMATION_____

## ICD-10 DIAGNOSIS CODE

**PLEASE CODE TO THE HIGHEST LEVE. Please Check All That Apply:**

**MASTECTOMY: [ ] RIGHT [ ] LEFT [ ] BILATERL**

- ☐ Z90.10-Acquired Absence of Breast
- ☐ Z90.13-Acquired Absence of Bilateral Breasts
- ☐ Z90.11-Acquired Absence of RIGHT Female Breast
- ☐ Z90.12-Acquired Absence of LEFT Female Breast

**PARTIAL MASTECTOMY: [ ] RIGHT [ ] LEFT**

- ☐ I97.2-Post-Mastectomy Lymphedema
- ☐ I89.0-Lymphedema, Not Elsewhere Classified
- ☐ _____OTHER DIAGNOSIS CODE
- ☐ _____ OTHER DIAGNOSIS CODE

## MASTECTOMY GARMENT ORDER

| | | |
|---|---|---|
| ☐ External Breast Prosthesis Garment with Mastectomy Form (Camisole type undergarment used post mastectomy) | Code L8015 | Qty:____ |
| ☐ Mastectomy Bras (Pocketed Bras to hold Breast Prostheses) | Code L8000 | Qty:____ |
| ☐ Compression Bra / Mastectomy Bra with Integrated Prosthesis | Code L8001/L8002 | Qty:____ |
| ☐ Foam Breast Prostheses (Normal Daily Wear) | Code L8020 | Qty:____ |
| ☐ Silicone Breast Prostheses (Normal Daily Wear) | Code L8030 | Qty:____ |
| ☐ CUSTOM Silicone Breast Prostheses | Code L8035 | Qty:____ |
| ☐ Lymphedema / Mastectomy Sleeve | Code L8010/S8424 | Qty:____ |
| ☐ Gradient compression Stocking/Sleeve, Not Otherwise Specified | Code A6549 | Qty:____ |
| ☐ Other: | | |

## ORDERING PHYSICIAN INFORMATION AND AUTHORIZATION

I certify that the above prescribed equipment/medication is MEDICALLY NECESSARY for this patient's wellbeing. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice and treatment of this patient's condition. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

**PHYSICIAN NAME (PRINT):** _____ **NPI:** _____
(REQUIRED)

**PHYSICIAN SIGNATURE:** _____ **ORDER DATE:** _____
(REQUIRED)

**PHONE:** _____ **FAX:** _____

**PRACTICE ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in CMS Internet-Only Manuals